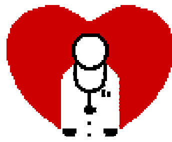

Consent for Medical Treatment

New Prairie United School Corporation
5327 N. Cougar Road
New Carlisle, IN 46552
574-654-7273 or 219-778-2814

I, (We) ____ of
Parent(s) or Legal Guardian(s)

____, do hereby state
Address City State Zip Code

that I am (We are) the parent(s) or legal guardian(s) of _________________________,
Student's name

age ___________, born ______________, who resides with me (us).
Month, day, year

I (We) authorize personnel employed by the New Prairie United School Corporation to consent to any necessary examination, anesthetic, medical diagnosis, surgery or treatment, and/or hospital care to be rendered to the above named minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine in the state of Indiana. This consent shall be valid for the duration of enrollment of the 2006-2007 school year.

Dated this ________ day of ___________________, ________.
Date Month Year

____________________________ ____________________________
Signature of parent or legal guardian Signature of parent or legal guardian

Family physician _____________________Office phone _____________________
Medical Insurance Carrier ____
Identification number ____
Member's name ____
Benefit code _______________________ Account number ___________________

Medical history (allergies, if any, including medication)
____
____

Medicines your child is currently taking
____
____

Emergency Contact Information	
Name and Relationship	Contact Number
★Parent(s)/Legal guardian(s) →	
1.	
2.	
3.	