CONSENT TO TREAT

I, _____, parent or legal guardian of

_____, hereby give my consent for the administration of any treatment deemed necessary for the welfare of the above named child, determined by a physician, qualified nurse, dentist, and/or hospital in the event of injury or illness during all periods of time in which the student is away from his/her legal residences as a member of any interscholastic activity team or group and hereby waive on behalf of myself and the above named child any liability of the CUSTER COUNTY SCHOOL DISTRICT CCSD-1, any of its agents or employees, arising out of such medical treatment. **This authorization is effective from August 1, (insert year) through July 31, (insert year).**

Parent/Guardian Signature: _____

Parent/Guardian Printed Name: _____

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment.

Student's Name: _____

Student Date of Birth:_____

Family address: _____

Father/Guardian Name: _____Phone: _____

Mother/Guardian Name:_____ Phone: _____

Allergies to drugs or foods:

_____

_____

Special Medications, Medical Conditions, Blood Type or Pertinent Information

_____

_____

Child's Physician _____ Phone _____

Insurance _____ Policy # _____