

MPS 2010 Medical Procedures for Minors

Parental Consent is needed for medical treatment and procedures deemed as necessary in case of an emergency. Please read this form carefully and fill in all information completely.

PLEASE PRINT

I, _____, do hereby authorize emergency treatment by a
(Parent or Legal Guardian)
qualified physician or dentist for my son/daughter _____
(Name)

during the period from _____ to _____.
(Date) (Date)

Our family physician is Dr. _____

Our family physician's address is _____
(Street)

(City) (State) (Zip)

Our Family physician's phone number is (_____) _____

Our family dentist is Dr. _____

Our family dentist's address is: _____
(Street)

(City) (State) (Zip)

Our family dentist's phone number is (_____) _____

In case of an emergency, I want my son/daughter taken to the nearest hospital
Emergency Room for treatment. Our family Health insurance is carried by:

(Company)

(Policy #)

Notary Public _____ Seal:

My commission expires _____

Student's Name: _____
(Last) (First) (MI)

Date of Birth: ____/____/____ (MM/DD/YYYY) Age: _____

Address: _____
(Street)

(City) (State) (Zip Code)

Student's Social Security No: _____ Phone: (____) _____

Parent or Guardian

Name: _____

Address: _____
(Street)

(City) (State) (Zip Code)

Phone(s): (____) _____ (____) _____ (____) _____
(Home Number) (Work Number) (Cell Number)

Health History (Check all that apply):

- ____ Diabetes
- ____ Orthopedic Problems
- ____ Asthma
- ____ Epilepsy
- ____ Cardiac Problem
- ____ Other (Please specify below)

Allergies (Check all that apply):

- ____ Aspirin
- ____ Penicillin
- ____ Sulfa
- ____ Insect Stings
- ____ Tetracycline
- ____ Other Medications

Do we have your permission to administer to your child over the counter medications such as aspirin, Tylenol, or Advil? ____ Yes ____ No

Has your child had a current tetanus shot (within six (6) years)? ____ Yes ____ No

Do you know of any health factors that make it advisable for your child to follow a limited program of physical activity or from participating in any of the clinic activities?

If yes, please explain. Mention any recent surgery, illness, broken bones, injuries, allergies (other than drugs) or other physical conditions:

PARENT'S AUTHORIZATION

This health history is correct to the best of my knowledge and the student herein described has permission to engage in all activities, unless otherwise noted by me. I give permission in my absence; the medical staff on-site and/or at any medical facility, may hospitalize, secure proper treatment for, and order medications, injections, anesthesia or surgery for my child if the need arises.

Parent/Guardian Signature

Date