TOWNSHIP HIGH SCHOOL DISTRICT 211

Transition Services

MEDICAL CONSENT FORM

STUDENT NAME_____ BIRTHDATE_____

ADDRESS_____ CITY_____ ZIP CODE_____

HOME PHONE_____ WORK PHONE_____ _____
Mother Father

EMERGENCY CONTACT_____ PHONE_____

MEDICAL DOCTOR_____ PHONE_____

LIST OTHER DOCTORS CARING FOR YOUR CHILD_____

Describe any medical problems or special concern/restrictions (lifting, standing, etc.) that may effect your child in a working environment_____
_____
_____
_____

Seizure History (if any, please fill in back side of this document)

List all medications your child receives (name, amount, frequency)_____
_____
_____

List allergies to drugs, foods, etc._____
_____

As a parent and/or guardian, I do authorize the treatment by a qualified and licensed medical doctor of the above mentioned minor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment or undo discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances, in my absence. I authorize the release of this information to Township High School District 211 and adult service providers.

PARENT/GUARDIAN SIGNATURE_____ DATE_____

PARENT/GUARDIAN NAME (PLEASE PRINT)_____
RELATIONSHIP_____