MEDICAL CONSENT FORM

Consent for Medical/Surgical Care/Emergency Treatment & Medical Information

STUDENT'S LEGAL NAME ____

Parent/Guardian Name ____

Signer's relationship to student: Father Mother Other ___________________________________

I hereby give our/my consent to George Stone School for the period of 18 months following the date of my signature below, to arrange for routine or emergency medical/dental care and treatment necessary to preserve the health of our/my child.

I acknowledge that I am responsible for all reasonable charges in connection with care and treatment rendered during the period beginning at the date of the signature below and for eighteen months forward.

Parent/Guardian Address	**Student's Residence**
Address ______________________	Address ______________________
City__________________________	City ________________________
State______________ ZIP__________	State ______________ ZIP__________
Phone_________________________	
Family Physician	**Pediatrician**
Name__________________________	Name ________________________
Address ______________________	Address ______________________
City _________________________	City ________________________
Phone ________________________	Phone ________________________
Health Insurance Carrier	**Student's Allergies**
______________________________	______________________________
Group No. ____________________	______________________________
Agreement No. ________________	**Date of last tetanus**________________
IN CASE OF EMERGENCY I CAN BE REACHED AT	**Medications student is taking**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Signature of Parent/Guardian (Signature remains in effect for 18 months)