Medical Concent Form - Permission to Treat

Child's Name			Date
Child's Physician's Name			Phone
Address			
Child's Dentist			Phone
Authorised Adults who will give consent			
Please indicate the names and contact information of authorised persons			
Father's Name	Hm #	Wk #	Cell #
Mother's Name	Hm #	Wk #	Cell #
Other Authorised Person Name	Hm #	Wk #	Cell #
Other Authorised Person	Hm #	Wk #	Cell #
Address			
First Aid			
In the event of an emergency, I authorise the staff of Stargate Montessori to provide first aid care			
deemed necessary for my child.			
Parent's Signature / Date			
Emergency Cate			
In the event of an emergency, in which I cannot be reached, the Physician listed above or the			
locall hospital are authorised to provide any emergency care deemed necessary for my child.			
Parent's Signature / Date			
Health Record Transfer			
In the event of an emergency, I authiorise the transfer of my child's health records to the			
appropriate medical team.			
Parent's Signature / Date			
Hospital of Choice			
I would like my child to be transported to the folloiwing hospital via ambulance if needed.			
Hospital Name			
Insurance Company			
ID Number		Subscriber Name	
Additaionsl Instructions : Please list any allergies your child may have			