

CONSENT FOR TREATMENT OF A MINOR 2017- 2018
St. John School

In the event of a non life-threatening emergency at which time I cannot be reached, I

_____, residing at _____,
(Parent or Legal Guardian)

_____, hereby entrust the care of my _____,
(Address, city, state zip)

child(ren) listed below to the teachers and staff of Saint John School located at:

Saint John School
106 Military Street
Georgetown, KY 40324

to consent to necessary examination, anesthetic, medical diagnosis, surgery or treatment, and/or hospital care as deemed necessary by a physician. I understand this consent is valid until such time as revoked in writing or said minor is emancipated.

_____ born _____
(Minor's name and grade) (Birthday)

_____ born _____
(Minor's name and grade) (Birthday)

_____ born _____
(Minor's name and grade) (Birthday)

_____ born _____
(Minor's name and grade) (Birthday)

Please list below child's name and any allergies/medical problems, if applicable:

2) Name and address of child's physician:

3) Insurance Name & Policy Number:

4) Name of person insured & place of employment: _____

(Signature of Parent)

(Date signed)