Emergency Consent to Treatment

Purpose: to enable Parents to authorize the emergency treatment for children who become ill or injured while under school authority, when every reasonable effort has been made to contact the Parents.

We, _____, as Parents of the minor child listed below, consent to any x-ray, examination, anesthetics, medical, or surgical diagnosis or procedure deemed necessary for my child's treatment by our family Physician.

Dr. _____M.D., or the emergency Physician on duty at a licensed hospital.

Family Physician's Phone Number: _____

Name of Child: _____

Date of Birth: _____

ALL known allergies: _____

_____

_____

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, and is given to encourage said Physicians to exercise their best judgment as to requirements of such diagnosis or treatment.

This consent shall remain in effect for the _____-_____ school year unless sooner revoked in writing and delivered to the Genesis Prep Academy office.

Signature of Parent or Guardian _____ Date _____