Medical Treatment Consent Form
For Minors

Child's Name ______________________ Date of Birth ______________________

Address ____

Father's Name ______________________ Employed at: ______________________

Home Phone ______________________ Business ______________________

Mother's Name ______________________ Employed at ______________________

Home Phone ______________________ Business Phone ______________________

IF PARENTS ARE NOT AVAILABLE IN AN EMERGENCY, CONTACT:

Name ______________________ Phone Number ______________________

Address ____

Relationship to Child ____

Child's Doctor ______________________ Family Doctor ______________________

Child is Allergic to: ____

Medical Information (including last Tetanus shot, major illness) ______________________

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Insurance Company ______________________ Policy Number ______________________

Responsible Party ____

Medical Treatment Consent for Minors

Dear Parents or Guardian: This card should be presented to the attending physician if your child is in need of medical treatment during your absence. Have each of your minor children (through age 18) carry a card with them or have it available when you are absent. This card will prevent delay of treatment for your child because of lack of proper authorization. Individual hospitals or physician offices may require additional authorization. I hereby authorize the treatment, administration of anesthesia and surgical treatment(s) for my minor child: ______________________________
in the event of a medical situation occurring during my absence or when the hospital or physician(s) are unable to contact me. This authorization extends to any hospital or physician office and nursing personnel within the hospitals or physician office, medical authorities and physicians for performing medical procedures acting on the authority of this medical treatment consent form which are deemed necessary to my minor child.

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Signature of Parent or Legal Guardian Date

____

Witness Date

LAST NAME____________________ **FIRST NAME** _________________ **GRADE** ___

Co-Curricular Permission Form
River View School

I hereby give my permission for ________________________ to compete in the co-curricular/athletic programs. I further agree to be financially responsible for the safe return of all athletic equipment issued to him/her.

I also attest to the fact that the above named student has not had a Significant operation, serious illness or injury requiring prolonged treatment.

PARENT: If there is any questions that this student may not Be qualified for co-curricular/athletic competition without a physical examination, contact your medical advisor before signing this form.

A girl/boy may participate in this activity if she/he is adequately insured by his/her family. Understand your insurance coverage before signing this form. The Kaukauna Area School District does **not** provide insurance coverage for participants involved in co-curricular activities and therefore is not liable in the event of an injury to a participant.

As parent or guardian, I am fully aware and accept that responsibility in the event an injury does occur. I am also aware and understand that the nature of co-curricular activities may result in an injury to participants.

______________________________ ______________________________
Student Signature Parent/Guardian Signature

______________________________ ______________________________
Date Home Phone/Emergency Phone