



PERMISSION TO TREAT

Name _____ Age _____ Date of Birth _____ Grade _____

Address _____ Phone _____

Parent/Guardian Name _____ Home Phone _____

Address _____ Work Phone _____

Insurance Co. _____ Policy # _____

Person to contact if parents cannot be reached:

Name _____ Phone _____

Family Doctor _____ Phone _____

Family Dentist _____ Phone _____

Medical History:

Allergies _____

Medications _____ Contact lenses Yes / No

Medical conditions _____

Date of last tetanus shot _____

We/I the parent(s)/guardian of _____ give permission for emergency medical treatment of this child in case of illness or accident.

Date _____ Parent/Guardian _____