

Medical Treatment Authorization and Consent

We, the parents of _____,

authorize _____ to give the following care to

our child while he/she attends school: _____.

Child's information:

Name: _____

Address: _____

Date of birth: _____

Parent's information:

Name: _____

Address: _____

Phone number: _____

Child's health information:

Health condition: _____

Allergies: _____

Medications (prescription): _____

Limitations: _____

Parent signature: _____

Date: _____