MONDOVI SCHOOL DISTRICT
MEDICAL TREATMENT CONSENT FORM

I hereby give my permission for any and all medical attention necessary to be administered to my child in the event of an accident, injury, sickness, etc., under the direction of the person(s) listed below until such time as I may be contacted.

Child's name _____

This release in effective for the time during which my child is participating in the_____ program for the _____/_____ season, including traveling to or from competition. I also hereby assume the responsibility for payment of any such treatment.
Parents/Guardian Names

_____
Home address (Street/City/State/Zip)

_____

Home/Cell Phone _____

Work Phone _____

Signature of Parent or Guardian

_____

TREATMENT CONSENT CONTINUED

Insurance Company _____

Policy Number _____

Family Physician _____

Physician's Phone Number _____

Physician's Address _____

_____

My child's known allergies _____

_____

In case I cannot be reached, please contact either of the following designated people:

Name_____

Phone Number _____

Name _____

Phone Number _____

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