PLEASE NOTE: BOTH PAGES of this form must be completed and submitted to the School Nurse before the student arrives on campus. Any student who does not have BOTH PAGES of this form completed *WILL NOT* be admitted to school. A signature of both parents/legal guardian who has custody of the student is required for this form to be valid.

ST. MARY'S PREPARATORY

CONSENT TO TREATMENT FORM

St. Mary's Preparatory recognizes its responsibility to provide medical services to its students, especially in time of emergency. The school retains a nurse during school hours who is available to care for any illness or injury to students. In order to adequately care for students, the following consent is required.

_____

STUDENT'S LAST NAME **FIRST NAME** **M.I.**

We (I) consent for the School Nurse of St. Mary's Preparatory to dispense over the counter medication and/or administer such medical treatment as he/she deems necessary or advisable in case of illness or accident.

In the event that a physician determines that immediate medical treatment or surgery is necessary for this student and one or both parents, and the legal guardian cannot be immediately contacted, authorities of St. Mary's Preparatory are hereby authorized to approve such treatment as may be determined by the physician at that time.

We (I) accept full responsibility for the cost of any medical care or emergency treatment which may become necessary. In authorizing St. Mary's Preparatory as our (my) agent, We (I) understand that the school shall not be held responsible for the payment of fees or charges and the school will accept billing in our (my) name only to facilitate submission of student accident insurance claims, if applicable, or for the prompt forwarding of billing to us (me).

This document is intended to be a release to those obtaining and supplying medical treatment (emergency & non-emergency), including St. Mary's Preparatory, any members of the school's administration or staff, its employees, and any physicians or institutions treating or offering medical assistance to the student.

_____

Mother/Guardian Signature Date

_____

Mother/Guardian (Print Name)

(_____)_____ (_____)_____ (_____)_____

Home Phone Work Phone Other

_____

Father/Guardian Signature Date

_____

Father/Guardian (Print Name)

(_____)_____ (_____)_____ (_____)_____

Home Phone Work Phone Other

CONTINUE TO NEXT PAGE

Student's Last Name **First Name** **M.I.**

Home Address City State Zip

MO:_____DAY:_____YEAR:_____ _____
DATE OF BIRTH Citizenship

Place of Birth

Date of last physical:_____

Does the student have any handicaps?

Does the student have any seasonal, environmental or food allergies?

Is the student currently taking any medications?

Is the student allergic to any medications? If so, please list:

NEAREST RELATIVE INFORMATION

List the name, address, and telephone number of the nearest relative, in the event that the ***parents or legal guardian*** cannot be reached:

Name

Home Address City State Zip

Relationship to student

(_____)_____ (_____)_____ (_____)_____
Home Phone Work Phone Other

INSURANCE INFORMATION

Name of Insurance Company providing coverage for student

Address City State Zip

(_____)_____ _____
Phone Policy Number

_____ (_____)_____
Family Physician's Name (Please Print) Family Physician's phone number