Authorization for Medical Consent

Medical Concerns

In the event that your child should receive an injury of a non-critical nature, but one that is of concern to us —May we call your child's physician IN THE EVENT THAT WE CANNOT REACH YOU? Yes _____ No _____

PHYSICIAN'S NAME _____ Office Telephone (____)_____

AUTHORIZATION FOR MEDICAL CONSENT

I hereby grant permission to The Rainbow School to seek medical attention for my child _____

In the event such treatment is deemed necessary, and I am unable to be contacted. I further consent to medical or surgical treatment by any licensed physician and/or hospital and further consent to administration of necessary anesthetics, medical tests, treatments, transfusions, injections, or drugs and the performing of whatever operation or procedure may be deemed necessary or advisable during his or her stay in the hospital.

Parent Name: (print) _____ Parent Signature _____

Date _____

Mother's Work Telephone (____)_____ Father's Work Telephone (____)_____

Mother's Cell Phone (____)_____ Father's Cell Phone (____)_____

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Parent Name: (print) _____ Parent Signature _____

Date _____

Mother's Work Telephone (____)_____ Father's Work Telephone (____)_____

Mother's Cell Phone (____)_____ Father's Cell Phone (____)_____