MEDICAL CONSENT FORM

To: Parents or Guardian:

This form is to be used in the event of an emergency and you cannot be reached. Please complete, have your signature notarized, and return this form to Rock County High School.

I,_____, _____
(Parent of Guardian) (Relationship)

of_____, _____
(Name of Student) (Age)

_____
(Social Security Number)

of_____
(Box number, City, State, and Zip Code)

_____, hereby authorize in advance any necessary
(Area Code & Phone Number)

medical treatment required by _____ while he/she is
(Student's Name)

participating in activities/school for the academic year_____.

Insurance
Group:_____

Policy
Number:_____

_____
(Parent or Guardian Signature)

Subscribed in my presence and sworn before me this_____ day of

_____, 20_____.

_____
(Notary Public)

SEAL: