Marion Community Schools

Raising the bar of excellence in education

(Policy #2340, #5330, #8660)
June 22, 2006

Authorization of Consent to Medical Treatment for Minor Child

I (We) _____ and _____
Name *Name*

of _____ _____ _____
City *County* *State*

do hereby state that I am (we are) the natural parent(s)/legal guardian(s) having legal custody

of _____ _____ _____
Student's Name *Student's Date of Birth* *Student's Age*

who resides with me (us) at: _____
Street Address

_____ _____ _____
City *State* *Telephone*

I (We) authorize school personnel to administer medication as indicated below and agree to inform the school in writing of any change in medication, dosage, or times of administration for the student while at school or participating in school activities. I (We), in addition, authorize school personnel in an emergency situation to consent to any X-ray, examination, and anesthetic, medical or surgical diagnosis or treatment, and hospital care to be rendered to the student under the general or special supervision and on the advice of a physician or surgeon licensed to practice in the United States until such time as parental consent is obtained.

Name of medication: _____

Purpose of medication: _____

Dosage of medication: _____

Time(s) when medication is to be administered: _____

Anticipated length of time student is to receive medication: _____

Physician's Name: _____ Telephone: _____

Dated this _____ day of _____, 20____.

_____ _____
Signature of Parent or Guardian *Signature of Parent or Guardian*

Note: Not valid unless all blanks are filled in. If not applicable, state "N/A" or "None".