



## AUTHORIZATION OF CONSENT FOR MEDICAL OR SURGICAL TREATMENT OF A MINOR CHILD

The undersigned is/are the parent(s) or legal custodian(s) of:

**STUDENT** \_\_\_\_\_ **GRADE** \_\_\_\_\_

who is temporarily in the care and custody of Countryside Christian School, 1901 East 4th Street, Pittsburg, KS 66762. By this document we authorize Countryside Christian School to obtain medical or surgical treatment for said child if we, the parents, cannot be reached at the time the child suffers an injury or illness requiring medical or surgical treatment. The undersigned will be responsible for the charges for any medical treatment or hospitalization rendered under this authorization.

Our private physician is: \_\_\_\_\_  
Phone Number \_\_\_\_\_

Preferred Hospital \_\_\_\_\_

**FATHER'S NAME** \_\_\_\_\_  
Home: \_\_\_\_\_  
Work: \_\_\_\_\_  
Cell: \_\_\_\_\_

**MOTHER'S NAME** \_\_\_\_\_  
Home: \_\_\_\_\_  
Work: \_\_\_\_\_  
Cell: \_\_\_\_\_

**MEDICAL INFORMATION** (chronic or existing medical problems, allergies, etc.)

\_\_\_\_\_  
\_\_\_\_\_

**MEDICINES YOUR CHILD IS TAKING NOW** \_\_\_\_\_

\_\_\_\_\_

### INSURANCE INFORMATION

NAME OF MEDICAL INSURANCE COMPANY \_\_\_\_\_

MEMBER'S NAME \_\_\_\_\_ ID# \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Guardian Date