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## **Medical Consent Form**

**\*NO FORMS WILL BE ACCEPTED WITHOUT NOTARY SEAL\***

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Please print legibly.

Participant's Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_

Home phone#: (\_\_\_\_) \_\_\_\_\_ Cell phone#: (\_\_\_\_) \_\_\_\_\_

Work phone#: (\_\_\_\_) \_\_\_\_\_ Other: (\_\_\_\_) \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_

Emergency Contact Person's Phone#: (\_\_\_\_) \_\_\_\_\_

Relationship to student: \_\_\_\_\_  
(Example: uncle/aunt, grandparent, friend of family, etc.)

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## **Family Medical history**

UNDERLINE ANY OF THE FOLLOWING THAT YOUR Mother, Father, Sisters or Brothers ever had: Cancer, Diabetes, High Blood Pressure, Tuberculosis, Epilepsy, Mental Illness, Goiter, Stroke, Heart Disease, Nephritis, Serious Allergies, Other: \_\_\_\_\_

## **Past History**

Please list any significant Illnesses/Surgeries that the participant has had. Include accidents, deformities, allergies.

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

Please list any medications the participant is currently taking. \_\_\_\_\_

Participant's Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_

The law requires that parental permission be obtained for medication, emergency treatment and operative procedures on minors. The parents should sign the following consent form so that emergency procedures may be carried out promptly, and so that no unnecessary delays occur with less urgent operative procedures. However, no operations will be performed, except in an extreme emergency without parents being contacted and fully informed.

I GIVE PERMISSION FOR SUCH MEDICAL PROCEDURES AS MAY BE DEEMED NECESSARY FOR MY CHILD.

\_\_\_\_\_  
Student's Name (print)

\_\_\_\_\_  
Parent's Name (print)

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date