



## Consent to Medical Treatment for Minor

*(please complete for each child enrolled)*

I hereby authorize any duly authorized physician, emergency medical technician, nurse, hospital, or other medical facility or medical provider to treat said minor for the purpose of attempting to treat or relieve any injuries received by said minor while he/she was a participant or observer of any activity at SVBC Preschool. I authorize any licensed physician or licensed medical provider to perform any procedure which he/she deems advisable in attempting to treat or relieve any injuries, health emergency, or any related unhealthy conditions of said minor that he/she may encounter while in attendance at SVBC Preschool. I consent to the administration of anesthesia as deemed advisable by any licensed physician or licensed medical provider. I realize and appreciate that there is a possibility of complications and unforeseen consequences in any medical treatment, and I assume any such risk on the behalf of myself and said minor. I acknowledge that no warranty is being made as to the results of any treatment.

PARENT/GUARDIAN SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

Do the staff and volunteers of SVBC Preschool have permission to take emergency procedures that they deem necessary in the event your child is hurt or experiences a health crisis?

YES                  NO                  (Please circle your selection)                  \_\_\_\_\_ Please initial

Do the staff and volunteers of SVBC Preschool have permission to call emergency personnel if they deem it necessary?

YES                  NO                  (Please circle your selection)                  \_\_\_\_\_ Please initial

Do the staff and volunteers of SVBC Preschool have permission to transport your child in a personal vehicle if they deem it necessary for purposes of medical treatment or intervention?

YES                  NO                  (Please circle your selection)                  \_\_\_\_\_ Please initial

Current Medications Taken: \_\_\_\_\_

\_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Environmental Allergies: \_\_\_\_\_

Food Allergies: \_\_\_\_\_

Medical Problems: \_\_\_\_\_

\_\_\_\_\_

Physical Limitations: \_\_\_\_\_

\_\_\_\_\_

Hearing Limitations: \_\_\_\_\_

Vision Limitations: \_\_\_\_\_

Pediatrician: \_\_\_\_\_

Pediatrician Practice Name: \_\_\_\_\_

Practice Phone Number: \_\_\_\_\_

If your child needs to be transported by ambulance for medical treatment or attention, what is your preferred hospital for treatment?