

W I N T E R I M 2010

Consent to Treat Form Bosque School

AUTHORIZATION FOR MEDICAL SERVICES

I (We) request that I (we) be contacted within a reasonable time in the event of illness requiring medical services. In the event that I (we) cannot be reached, I (we), parent(s)/guardian(s), hereby designate appropriate school personnel, medical staff, or other officials to act in my (our) behalf to authorize such hospitalization, medical attention and surgery as may be required in an emergency while participating in school-sponsored events. In the event I (we) cannot be reached and the situation calls for medical attention, I (we) recognize and relinquish my (our) responsibility to a practicing physician and/or medical personnel acting in the best interest of my (our) child. I (We) assume financial responsibility for such services. I (We) recognize Bosque School faculty as temporary guardians for my (our) child from March 8 – 12, 2010.

STUDENT: _____
(PLEASE PRINT)

PARENT/GUARDIAN: _____ DATE: _____
(SIGNATURE)

EMERGENCY CONTACT NUMBER(S): _____

- **Return to Program Leader by Friday, February 12.**

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W I N T E R I M 2010

Updated Medical and Emergency Contact Information

Program: _____

Leader(s): _____

Student Name: _____

Birth date: _____

Student Home Address: _____

Father's name: _____

At home during Winterim? YES or NO

Mother's name: _____

At home during Winterim? YES or NO

Father's home phone #: _____ Work #: _____ Other #: _____

Mother's home phone #: _____ Work #: _____ Other #: _____

If parents will not be locally available during Winterim, where will they be and how can we contact them? _____

In case of illness or injury, and inability to contact parents, the school is authorized to notify:

Name: _____ Home phone: _____

Relationship to student: _____ Work phone: _____

Physician: _____ Phone: _____ Address: _____

Dentist: _____ Phone: _____ Address: _____

Insurance (Bosque requires proof of insurance for students involved in field trips)

Insurance Co.: _____ Policy #: _____

My child has the following health condition (for example, diabetes, ADD, asthma, seizures, etc.):

My child has these allergies (food, insect bites, pollen, medication, etc.): _____

Other health related issues: _____

Is your child presently taking, or will you send your child on this program with, any medications? _____

If yes, which medications: _____

Attach dosage instructions and discuss the situation with a Bosque School program leader.

Does your child have any mandatory diet restrictions (if yes, please specify) : _____

Do you have any other concerns you would like to relay to the program leaders? _____

Parent/Guardian: _____ Date _____

• **Return to Program Leader by Friday, February 12.**

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