# CONSENT TO TREAT MINOR CHILDREN

I, _____, parent or legal guardian of

_____, born the _____ day of _____,

in the year_____ do hereby consent to any medical care and treatment determined by a physician to be necessary for the welfare of my child while said child is under the care of the Faculty and Staff of Faith Academy of 4300 N Corrington Avenue, City of Kansas City, State of Missouri and I am not reasonably available by telephone to give consent. Medical expenses incurred during the treatment of my child is solely my obligation as parent or legal guardian,

This authorization is effective from the _____ day of _____, 20___ until written notification to revoke this consent is provided to Faith Academy and placed in my child's student record file.

_____ _____

**Signature of Parent or Legal Guardian** **Date**

_____ _____

Witness Signature Witness Name (please print)

This consent form should be taken with the child to the hospital or physician's office when the child is taken for treatment. This additional information will assist in treatment if it can be furnished with the consent but is not required.

Family Address _____

Father's Telephone: _____ Mother's Telephone: _____

Last Tetanus: _____

Allergies to drugs or foods: _____

Special Medications, Blood Type or Pertinent Information: _____

_____

Child's Physician: _____ Phone: _____

Insurance: _____ Policy # _____

Preferred Hospital: _____