CONSENT TO TREAT MINOR CHILDREN

I, Type Parent's Full Name., parent or legal guardian of Type Student's Full Name, born on the enter a date. day of Month of birth in the year of Year of birth. 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 Harvest Christian School located at 4300 N Corrington Avenue, in the 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 Click or tap to enter a date until written notification to revoke this consent is provided to Harvest Christian School and placed in my child's student record file.

Click or tap here to enter electronic signature.

_____ 3/24/2021

Signature of Parent or Legal Guardian **Date**

_____ _____

Staff Signature Staff 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: Click enter complete address with city, state and postal code.

Father's Cellphone: Insert 10-digit number. Mother's Telephone: Insert 10-digit number.

Last Tetanus: Click or tap to enter a date.

Allergies to drugs or foods: Click or tap here to enter text.

Medications, Click or tap here to enter text.
Blood Type Click or tap here to enter text.
Other information: Click or tap here to enter text.

Child's Physician: Click or tap here to enter text. Phone: Click or tap here to enter text.

Insurance Company: Click or tap here to enter text
Policy # Click or tap here to enter text. Group #: Click or tap here to enter text.