CONSENT TO TREAT A MINOR CHILD

I hereby authorize Shawnee Mission East Choirboosters Club and its chaperones to seek medical treatment for my child in the event of a medical or traumatic emergency.

I consent to medical or surgical treatment by any licensed provider and/or facility and further consent to administration of necessary anesthetics, medical treatments, tests, suturing, X-rays, drawing of blood for tests, transfusions, injections or drugs, and the performing of whatever operations may be deemed necessary or advisable. I understand I am responsible for the cost of treatments.

**PLEASE COMPLETE:**

Name of child:

Child’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any chronic diseases or allergies (including drug allergies) that might interfere with emergency medical or surgical treatment ­­­ \_\_\_\_\_ YES \_\_\_\_\_ NO

If yes, please detail on the attached Health History Form

Is your child taking any medication(s)? \_\_\_\_\_ YES \_\_\_\_\_ NO

If yes, please detail on the attached Health History Form

**PARENT/GUARDIAN:**

Parent/Guardian’s Name:

Address: Home Phone:

 Cell Phone:

Email:

In case of an emergency and you are unavailable, please provide an additional emergency contact:

Name:

Address:

Phone:

**Primary Medical Insurance** ID#

Group #: Subscriber Name:

**Secondary Insurance** ID#

Group #: Subscriber Name:

**Child’s Physician**

Address/Telephone:

This authorization is valid from March 12, 2020 through March 21, 2020.

Signature of Parent or Legal Guardian

IN WITNESS WHEREOF I have hereunto subscribed my name and affixed my official seal this \_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_.

My Commission expires:

(Signed)