

CONSENT FOR EMERGENCY MEDICAL TREATMENT State Mandated Form for Elementary School-Age and Preschool Children

AS THE PARENT, DOMESTIC PARTNER, OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE
CONSENT TO **CREATIVE FRONTIERS SCHOOL, INC.** TO OBTAIN ALL EMERGENCY MEDICAL AND OR
DENTAL CARE PRESCRIBED BY A DULY LICENSED PHYSICIAN (D.O.) OSTEOPATH (D.O.) OR DENTIST

(D.D.S.) FOR _____ . THIS CARE MAY BE GIVEN UNDER
NAME OF CHILD

WHATEVER CONDITIONS ARE NECESSARY TO PRESERVE THE LIFE, LIMB, OR WELL-BEING OF THE
CHILD NAMED ABOVE. IN ADDITION, PLEASE NOTE BELOW RELEVANT MEDICAL INFORMATION.

STATEMENT OF KNOWN ALLERGIES

PLEASE INDICATE BELOW THE VARIOUS THINGS THAT YOU BELIEVE YOUR CHILD IS ALLERGIC TO:

INFORMATION REGARDING OTHER KNOWN & RELATED MEDICAL ISSUES

PARENT, DOMESTIC PARTNER, OR AUTHORIZED REPRESENTATIVE SIGNATURE DATE: ____ / ____ / 20 ____

IN CASE PROOF OF SIGNATURE ABOVE IS REQUIRED BY AN OUTSIDE FACILITY, PLEASE FILL IN INFORMATION BELOW:

HOME ADDRESS: _____

HOME PHONE: (____) ____ - _____ WORK PHONE: (____) ____ - _____ CELL PHONE: (____) ____ - _____

MOTHER'S SOC SECURITY # ____ - ____ - _____ **DRIVER'S LIC NUMBER:** _____ **BIRTHDATE:** ____ / ____ / ____

FATHER'S SOC SECURITY #: ____ - ____ - _____ **DRIVER'S LIC NUMBER:** _____ **BIRTHDATE:** ____ / ____ / ____