Permission to Treat

Name: _____ **Age:** _____ **Date of Birth**_____ **Grade**_____

Address: _____ **Phone:** _____

City: _____ **State:** _____ **Zip** _____

Parent / Guardian Name: _____ **Phone:** _____

Address: _____ **Work Phone:** _____

Insurance Co. _____ **Policy #** _____

Please list if you have a Hospital Preference:

Name of Hospital: _____ **Phone #** _____

Person to contact if parents cannot be reached:

Name: _____ **Phone:** _____

Name: _____ **Phone:** _____

Family Doctor: _____ **Phone:** _____

Family Dentist: _____ **Phone:** _____

Allergies _____

Medications _____ **Contact Lenses Yes No**
Circle one

Medical Conditions _____

Date of last Tetanus shot _____

We/ I the parent(s) / guardian of _____
Please Print clearly or type
give permission for emergency medical treatment of this child in case of illness or accident.

Date: _____

Parent / Guardian: _____