PARENTAL CONSENT/DELEGATION FOR MEDICAL TREATMENT

Parent/Legal Guardian of (name of child) ________________________________ hereby authorizes the personnel of the Brunswick Central School District to grant consent to any physician he or she deems appropriate to conduct the required tests and provide necessary medical treatment/care to the above named child IF I OR MY SPOUSE CANNOT BE REACHED.

Child's Date of Birth: ____

Date of Child's Last Tetanus Immunization: ____

Pertinent Medical Date: (Allergies, asthma, seizures, etc. Also include any medication your child is on relative to the condition.) ____

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Medical Restrictions: ____

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Parent/Legal Guardian:

Mother's Name: ______________________________

Home Address: ______________________________

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Home Telephone No.:__________________________

Place of Employment:__________________________

Work Telephone No.:__________________________

Cell Phone No.:______________________________

Father's Name:________________________

Home Address: ________________________

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Home Telephone No.:____________________

Place of Employment:____________________

Work Telephone No.:____________________

Cell Phone No.:________________________

Parent/Legal Guardian Signature:____

Printed Name:____ Date:____________________

Authorization expires one (1) year from date signed by Parent/Legal Guardian.

ACKNOWLEDGEMENT

STATE OF NEW YORK)
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COUNTY)

On this ____________ day of _________________________ 20_________, before me personally appeared ______________________________________, to me known to be the person(s) described in and who executed the foregoing instrument, and acknowledged that he/she (they) executed the same as his/her free act and deed.

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