



Information and Consent
to MEDICAL CARE and TREATMENT

One form to be completed for each person attending KURSA (please print).

NAME
Last First Middle

ADDRESS
Street
.....
City State Zip code

BIRTH DATE / / AGE MALE FEMALE
Month / Day / Year

ALLERGIES: (Food, Drugs, Etc.)
.....

SPECIAL HEALTH CONCERNS:
.....

LIST ALL MEDICATION THAT WILL BE BROUGHT TO KURSA:
.....
.....

ARE ALL SHOTS CURRENT? YES NO TETANUS "DPT" POLIO.....

HOME PHONE.....
MOTHER'S WORK PHONE..... MOTHER'S CELL PHONE.....
FATHER'S WORK PHONE..... FATHER'S CELL PHONE.....
FAMILY DOCTOR..... PHONE.....
INSURANCE COMPANY..... POLICY #.....

If more space is needed, please use back of form.

CONSENT TO MEDICAL CARE AND TREATMENT

If your child needs emergency treatment and is under the age of 18, hospitals are required by law to reach you for authorization to medically treat your child, except in the case of truly lifethreatening problems. **Only a parent or legal guardian may give this authorization.** If you are not available to sign the consent, and all attempts have been made to reach you and you cannot be reached within a reasonable time, you can ensure emergency treatment for your child by completing this form.

IF I CANNOT BE REACHED IN CASE OF EMERGENCY,

I,
Parent or Legal Guardian

AUTHORIZE ALL MEDICAL, SURGICAL, DIAGNOSTIC AND HOSPITAL PROCEDURES AS MAY BE PERFORMED OR PRESCRIBED BY A TREATING PHYSICIAN FOR

.....
Child's Name

.....
Signature of Parent or Guardian Date