

USD #385 DEPARTMENT OF HEALTH SERVICES
APPOINTMENT OF AGENT FOR CONSENT TO TREATMENT FOR EMERGENCY CARE

I, _____, parent or legal guardian of _____, do hereby consent to any hospital, medical or surgical care and treatment, and the administration of anesthesia, determined by a qualified physician to be necessary for the welfare of my child while said child is under the care, custody and control of the Andover Central High School Vocal Music Director, and I am not reasonably available by telephone to give consent.

State of _____

County of _____

Signed or attested before me on _____ (Date)

By _____ (Parent/Legal Guardian Signature)

_____ (Signature of Notary)

_____ Title

My appointment expires: _____.

THIS ADDITIONAL INFORMATION WILL ASSIST IN TREATMENT IF IT CAN BE FURNISHED WITH CONSENT, HOWEVER IT IS NOT REQUIRED.

Family Address _____

Telephone Numbers

Father at work _____

Home _____

Mother at work _____

Home _____

Cell Phone _____

Pager _____

Date of Birth _____

Last Tetanus _____

Current Medications _____

Allergies to drugs _____

Allergies to foods _____

Special medical treatments _____

Significant current/past medical conditions (Please list and explain) _____

Family Physician _____

Phone _____

Insurance Co _____

Phone _____

Must we call your insurance company or physician prior to any medical treatment?
