# Payson Unified School District #10

## CONSENT TO MEDICAL TREATMENT

**Campus:** ______________________________ **Grade:** ________ **School Year:** _______________

**Student Name:** ________________________________________ **Date of Birth:**________ **M / F**
Last First Middle

**Physical Address:** ______________________________________________________________

**Mailing Address:** ______________________________________________________________

**Mother's Name:**______________________________ **Father's Name:**______________________________

**Home #:** ______________________________ **Home #:** ______________________________

**Work #:** ______________________________ **Work #:** ______________________________

**Cell #:** ______________________________ **Cell #:** ______________________________

**TWO emergency contacts other than parent/guardian are required:**

1. **Name:** ______________________________ **Relation:**____________ **Phone:**____________
2. **Name:** ______________________________ **Relation:**____________ **Phone:**____________

**Primary Doctor:**________________________________________ **Phone:**__________________

## CONSENT TO MEDICAL TREATMENT

I, ______________________, am the natural parent or legal guardian of ______________________, a minor student age _____. I authorize assigned certificated staff or appointed designee, in the Payson Unified School District #10, State of Arizona, to consent to any X-ray, examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care, to be rendered to the student under the general or special supervision and on the advice of any licensed physician or surgeon, when the need for such treatment is clear and when efforts to contact me are unsuccessful. If it is necessary to call 911 to transport your child to the hospital the school is authorized to do so.

**X Parent/guardian signature:** ____________________________________ **Date:**________________

During the course of the school year we often find it advisable to use ingested or topical medication in the treatment of minor injuries or illnesses. A few such conditions are sore throats, cough, headaches, stomach aches, scratches, blisters, etc. Arizona State law prohibits us from treating any conditions without the written consent from the parent. **The administration of PRESCRIPTION drugs requires the written permission of the parent**. Forms are available from your school's Health Specialist.

The products or their generic equivalent that we use most often in the Payson Unified School District #10 are listed below. If you **DO NOT** want your child to receive the benefit of any product listed below, please **CROSS OFF** the particular product below.

| | | | | |
|---|---|---|---|---|
| Acetaminophen (Tylenol, Equate, etc.) | Ambesol / Orajel | Cortisone cream / oint. | Ibuprofen | Vaseline |
| Antihistamine | Antibiotic cream / oint. | Cough drops / Lozenges | Midol | |
| Alcohol (topical) | Caladryl lotion | Derma Plast | Solarcaine | |
| Antacid | Camphophenique | Eye wash drops | Sore throat spray | |
| | Carmex | Hydrogen Peroxide | Sportscream | |

Please list any ALLERGIES your child may have: ______________________________________________

______________________________________________________________________________

SPECIAL MEDICAL NEEDS / DIAGNOSIS:__________________________________________________

______________________________________________________________________________

Current Medications and dose:_________________________________________________________

I hereby give permission for my child to receive any of the ingested or topical medications listed above.

**X Parent/guardian signature:** ____________________________________ **Date:**________________

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