

# USD 223 CONSENT FOR MEDICAL TREATMENT

(We) (I), the parent(s) and legal guardian(s) of the above named student consent to and authorize, for the 2020-2021 school year, any representative of USD 223 to determine need for medical treatment by any physician or dentist licensed in accordance with the provisions of the Kansas Healing Arts Act, Kansas Statutes Annotated 65-2801 and any hospital, as a result of injury or illness of an emergency nature while engaging in an activity being participated in by USD 223. We also give permission for him/her to be treated with basic first-aid including over-the-counter medications, while excluding all prescription medications. Please list students and any known allergies below.

*If no allergies, please put N/A*

Student's Name \_\_\_\_\_ Allergy \_\_\_\_\_

Student's Name \_\_\_\_\_ Allergy \_\_\_\_\_

Student's Name \_\_\_\_\_ Allergy \_\_\_\_\_

(We) (I) agree to pay and assume all responsibility for all medical hospital expenses and any services of an emergency nature, and charges for (my) (our) dependent(s), and that the school is not responsible for any medical hospital expenses and charges that are incurred in the medical treatment or hospitalization of (my) (our) dependent(s). A photocopy of this document shall have the same force and effect as the original.

To enable USD 223 to give better service in case of an injury, we would appreciate your cooperation in providing us with the following information:

Family Physician \_\_\_\_\_ Hospital of Choice \_\_\_\_\_

Medical Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

(Do you have a medical card? (i.e. KanCare) YES \_\_\_\_\_ NO \_\_\_\_\_

## Emergency Contact:

Name \_\_\_\_\_ Relationship to Student \_\_\_\_\_

Address \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell# \_\_\_\_\_

During the school year you may be contacted by the school nurse to discuss your child's health or health plan needs. By signing below, I affirm that the information given on this registration form is correct to the best of my knowledge and that the school will be notified of any new or changes in your child's health conditions or medications.

Permission is hereby given for any emergency treatment, deemed necessary by medical professionals, in case of accident or illness, and the absence of parent(s) or legal guardian(s), in activities participated in by USD 223.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date