

# Capital Christian School

310 Sheep Davis Road  
Concord, NH - 03301-5736 (603) 224-3641

2021-2022

## Medical Consent

---

Last name

First name

Middle name

### Medical Information

Allergies \_\_\_\_\_

Medication(s) currently taking \_\_\_\_\_

Date of last tetanus shot \_\_\_\_/\_\_\_\_/\_\_\_\_

### Emergency Information

Please list any medical problems or any special instructions to be used in an emergency.

---

---

### ICE - In Case of Emergency - Notify the following

Parent/Guardian #1 \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Parent/Guardian #2 \_\_\_\_\_

Cell Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Home Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Physician's Name** \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Office Phone (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Insurance Information**

Insurance Co. name

\_\_\_\_\_

ID # \_\_\_\_\_ Group # \_\_\_\_\_

**Consent**

**Medical:** I hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered to said minor under the general or special instruction of the above-named physician or any physician the school may call.

**First Aid:** I do hereby consent to reasonable and prudent first aid to be administered by school personnel to the said minor as circumstances merit.

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