



Chisholm Trail Academy

P.O. Box 717 ♦ Keene, TX 76059 ♦ (817) 641-6626 ♦ Fax (817) 556-2009

CONSENT TO TREATMENT & HEALTH INSURANCE INFORMATION

We, the undersigned parents/guardians of _____, a minor, do hereby appoint Chisholm Trail Academy as our representative for authorizing and consenting to medical care and treatment of any illness or injury that may occur while our child is in their custody between the dates of July 1, 2007 and June 30, 2008 while we are away or otherwise not immediately available to give consent.

Student has health insurance? Yes or No
Please include a copy of your child's health insurance card (both sides) with this form.

Present Health Insurance Company _____

Name of Primary on Policy _____ Policy # _____

Name of Child _____ Date of Birth _____

Address _____ Phone _____

City _____ State _____ Zip _____ Cell Phone _____

Parent(s) Name _____ Phone _____

Alternative contact in case of emergency _____ Phone _____

Physician _____ Phone _____

Drug Allergies (particularly anesthetics, penicillin or mycins) _____

Other Allergies _____

Has your child had any of the following?
Convulsions Kidney Ailment Diabetes Bronchitis
Heart Ailment Tuberculosis Epilepsy Asthma

Please list anything else that you feel is important to know about your child _____

Is your child currently taking prescription medication? If so, what and why? _____

Date of Last Tetanus Injection _____

Signature of Parent/Legal Guardian _____

Relationship to Student _____

Date _____

Witness _____