ポートランド日本語継承学校
Keisho Japanese School of Portland

AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT FOR MINOR CHILD

In case of an injury and/or sickness occurs to your child during the school hours and he/she requires emergency treatment, Keisho Japanese School of Portland (KEISHO) representative will accompany the child to the nearest emergency room at the parent(s)/ guardian(s)'s expense. This consent form is provided for the parent(s) or guardian(s) to authorize KEISHO to obtain emergency medical treatment if necessary. Please make sure to enter all requested information and your signature(s) after reading and understanding thoroughly.

I/We, _____ of _____
Print Name(s) City State

do hereby state that I am/we are the parent(s)/guardian(s) having legal custody of _____,
Print Name

a minor, age _____ , born on _____ , who resides with me/us
Birth Date

at _____.
Home Address

I/We authorize KEISHO in an emergency, when I/we cannot be contacted, to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis and/or treatment, and hospital care, to be rendered to the minor, at a recognized medical facility, under the general or special supervision of a licensed physician or surgeon.

Dated this _____ day of _____, 20_____.
For example , 15th Month

_____ _____
Signature Signature
Home Phone: ( ) _____ - _____ Home Phone: ( ) _____ - _____
Cell Phone: ( ) _____ - _____ Cell Phone: ( ) _____ - _____

Emergency Persons in case Parent(s)/Guardian(s) cannot be reached:
First Contact Name: _____ Relationship: _____
Primary Phone: ( ) _____ - _____ Secondary Phone: ( ) _____ - _____
Second Contact Name: _____ Relationship: _____
Primary Phone: ( ) _____ - _____ Secondary Phone: ( ) _____ - _____

Physician's Name: _____ Phone: ( ) _____ - _____
Address: _____
Child's Allergies: _____
Other Medical Conditions of the Child: _____
Medication Child is Taking: _____

Insurance Holder (Parent/Guardian) Name: _____
Employer: _____ Work Phone: ( ) _____ - _____
Employer Address: _____
Primary Medical Insurance: _____ Phone: ( ) _____ - _____
Insurance Company Address: _____
Insurance Policy Number: _____