

Consent to Provide Medical Care For residentially placed student

Student Last Name	Student First Name	Birthdate	Gender	Allergies
			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Parent/Guardian Name		Parent / Guardian Phone Number		
Physician Name		Physician Phone Number		

I, _____, parent/guardian of _____ (student name), do hereby consent to any medical care and medications administration determined by residential facility physician to be necessary for the welfare of my child while said child is under the care of Marklund Day School and I am not reasonably available to sign authorization for medication administration or treatment to give direct consent.

This will remain in effect as long as the student is enrolled at Marklund Day School. If you do not wish to have the above consent followed, an alternative plan must be submitted to the Marklund Day School office in writing.

Parent/Guardian Signature _____ Print Name _____ Date _____