**CONSENT FOR MEDICAL TREATMENT**

Parent/Guardian agrees the provider may consult with the child’s nurse or attending physician in regards to child’s health as needed. In the event that we should have questions regarding the health of the enrolling child we may contact one, or more, of the following sources for information.

**√** Hospital of choice and phone number Click here to enter text.

**√** Clark County Health District (702) 759-1301

Dr. Name: Click here to enter text. Phone Number: Click here to enter text.

Address: Click here to enter text.

In an emergency, I, Click here to enter text., (Parent/Guardian), give my authorization to, **Shenker Academy,** (Provider’s Name) and any local physician, dentist or hospital to provide medical care and/or transport my child at my expense.

Medical Plan: Click here to enter text. Policy #: Click here to enter text. Phone #: Click here to enter text.Does your child require additional accommodations? Explain Click here to enter text.

Are the problems serious enough to restrict your child’s activities? Explain Click here to enter text.

Describe, if any, special care required Click here to enter text.

Does your child have frequent colds?  Yes  No

List any allergies that staff should be aware of Click here to enter text.

Is your child currently taking prescribed medication?  Yes  No

Name of medication Click here to enter text. Reason Click here to enter text.

Signature of Parent/Guardian: Click here to enter text. Date: Click here to enter text.