WESTCHESTER AREA SCHOOL
456 WEBSTER AVENUE
NEW ROCHELLE, NY 10801
(914) 235-5799

NOTARIZED CONSENT TO TREATMENT

We, the undersigned parents or guardians of ____ a minor, do 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 ____________________ M.D. or any physician the school or organization may call, whether such diagnosis or treatment is rendered at the office of said physician or at a licensed hospital. It is understood that reasonable effort will be made to contact the doctor listed above before any other physician is called by the school or other organization.

It is further understood that this consent is given in advance of any specific diagnosis or treatment which might be required and is given to authorize WESTCHESTER AREA SCHOOL of the physician to exercise their best judgment as to the requirements of such diagnosis or treatment.

This consent shall remain in continuous effect until evoked in writing and delivered to the physician named above or to the school or organization entrusted with the custody of said minor.

The above student ______ is ________ is not covered by Health Insurance.

Present Health Insurance Company____

Policy Number____

Dated:____________________________

____
Fathers Signature

____
Mothers Signature

____
Legal Guardian

____
NOTARY PUBLIC