|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| LAKESIDE SCHOOL  Permission to Treat and Physician’s Statement Form | | | | | | | | | | |
|  | | |  |  | | | | |  |  |
|  | | |  |  | | | | |  | |
| Student’s Name | | |  | Date of Birth Grade in 2017-2018 | | | | | Sex | |
|  | | |  |  | | | | | | |
| Parent’s/Guardian #1 Name / Mobile Phone Number | | |  | Parent’s/Guardian #2 Name / Mobile Phone Number | | | | | | |
|  | | |  |  | | |  |  | | |
| Address |  |  |  | Parent #1 Home Phone | | |  |  | | |
|  | | |  |  | | | | | | |
| City, ST ZIP Code | | |  |  | | | | | | |
|  | | |  |  | | | | | | |
| Medical Information | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | |  |  | | | | |
| Insurance Provider | | | | |  | Subscriber ID # | | | | |
|  | | | | | | | | | | |
| Current Medications and Medications Allowed | | | | | | | | | | |
|  | | | | | | | | | | |
| Allergies/Symptoms and General Medical Notes | | | | | | | | | | |
|  | | | | | | | | | | |
| I authorize that my child be given emergency medical treatment to include first aid and CPR by a qualified staff member. I authorize Lakeside School, in the event of medical emergency, to contact Seattle’s Medic 1, a licensed ambulance service, or a legal representative (employee) of the school, to transport my student to the emergency facilities of Northwest Hospital or any duly licensed and accredited medical hospital. I authorize said physician or surgeon to examine the above-named student to administer emergency medical care and to arrange for any consultation by a qualified specialist necessary to insure proper care of any injury. | | | | | | | | | | |
|  | | | | |  |  | | | | |
| **Parent’s/Guardian’s Signature** | | | | |  | **Date** | | | | |
|  | | | | |  |  | | | | |
|  | | | | | | | | | | |
| **PHYSICIAN STATEMENT AND SIGNATURE (ALL FIELDS ARE REQUIRED)** | | | | | | | | | | |
| Student may participate in the following (please check):  Physical Education: Competitive Sports: Outdoor Program: Student Activities: | | | | | | | | | | |
|  | | | | | | | | | | |
| Limited/Restricted Participation (please describe): | | | | | | | | | | |
|  | | | | | | | | | | |
|  | | | | | | | | | | |
| Date of Most Recent Physical: Where Performed: | | | | | | | | | | |
|  | | | | | | | | | | |
| Doctor’s Name (please print): Telephone: | | | | | | | | | | |
|  | | | | | | | | | | |
| **Doctor’s Signature: Date:** | | | | | | | | | | |

**THIS FORM IS DUE JUNE 1 AND VALID FOR ONE YEAR**