THE GREENBURGH-GRAHAM UNION-FREE SCHOOL DISTRICT

1 SOUTH BROADWAY

HASTINGS-ON-HUDSON, NEW YORK 10706

(914) 478-1106 FAX (914) 613-0500

Consent for medical treatment

Student:_____ D.O.B_____

1. I, _____, hereby authorize the School Nurse and/ or other authorized personnel at Greenburgh Graham School UFSD to administer medical treatment to my child as necessary.

2. I further consent to urgent (emergency) treatment that my child may need while placed in care if I cannot be contacted at the time that such care becomes necessary, or when a physician determines that the time cannot be contacted at the time that such care becomes necessary, or when a physician determines that the time needed to secure my consent would endanger my child's immediate welfare.

3. I understand the Greenburgh Graham School UFSD will contact me in the event of any urgent matters concerning my child's health.

4. I understand that this authorization will remain in effect for the duration of my child's enrollment in school.

5. I understand that this authorization includes the administration of medication only if the following forms are also completed with proper supporting documentation:

    a. Consent/Physician Order for the use of Over-the-Counter (OTC) Medications
    b. Authorization to Administer Medications (including inhalants) in School

_____ _____

Parent/Guardian Signature Date