



DEPARTMENT OF AEROSPACE SCIENCE

CLOVER HIGH SCHOOL— SC-951

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REQUEST FOR MEDICAL TREATMENT OF A MINOR

To: Medical Doctor, Medical Facility Director, or Medical Facility Commander

I, _____, of _____
(Printed or typed name of Parent/Guardian) (Street / Route) (City) (State) (Zip)

give my consent to the Air Force Junior Reserve Officer Training Corps Instructor in Charge of my child/ward,

_____, _____
(Printed or Typed Name of Child/Ward) (Date of Birth)

who is participating in AFJROTC physical training, or making a school sponsored curriculum in action trip or visit, to bring my minor child/ward to your medical facility for the purpose of examination, and/or surgical procedure(s), which you are authorized to perform in accordance with current policies and regulations. I do further more herein freely give my consent for you to perform such examination, treatment, and/or surgical procedure(s), which you deem necessary to treat such injuries received in connection with physical training, or this trip/visit and/or illness arising during the trip.

My son/daughter has the following medical problems/allergies:

___ Allergy to any plant, food or animal: _____

___ Allergy to any drug or insect toxin: _____

___ Any condition requiring regular medication, diet or special care: _____

Asthma, ___ Convulsions, ___ Heart, ___ Diabetes, ___ Other (please explain)

Is taking the following medication(s)/medicine(s): _____

Our family doctor is: _____ of _____

Name of Doctor

(Street/Route)

(City)

(State)

(Zip)

Whose phone numbers are: _____

I understand and agree that I will be responsible for all medical treatment cost. He/She is covered by School Accident Insurance or medical insurance coverage provided by the

(Insurance Company)

Policy No: _____

Parent/Guardian Signature

Home Telephone Number

Cell Phone Number

Date: _____