

**Good Shepherd Catholic School**  
**75 Shepherd Way Frankfort, KY 40601**  
**Consent for Medical Treatment**  
**K-8 Aftercare 2018-2019**

As a parent or guardian I grant permission to allow the staff and volunteers of the GSCS Aftercare program 2018-2019 to make decisions for emergency treatment, first aid, or hospitalization for my child if necessary. I understand that if an emergency should arise I will be notified first, but if I am unavailable to be reached by phone, such medical treatment as deemed necessary by trained and competent medical personnel is authorized.

I understand that this is a legally binding release and consent that Aftercare activities are provided in consideration for this signed release and consent.

I have carefully read this Consent for Medical Treatment form and fully understand and agree to its contents. I grant the staff of Good Shepherd Catholic School Aftercare 2018-2019 the power to act on my behalf in seeking medical attention for my child(ren).

**Print Child(ren)'s Name(s)** \_\_\_\_\_ **Age** \_\_\_\_\_  
\_\_\_\_\_ **Age** \_\_\_\_\_  
\_\_\_\_\_ **Age** \_\_\_\_\_

**Print Parent/Guardian's Name** \_\_\_\_\_

**Parent/Guardian's Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Medical Insurance Information:**

**Name on Card** \_\_\_\_\_

**Name of Carrier** \_\_\_\_\_

**ID Number** \_\_\_\_\_ **Group Number** \_\_\_\_\_

**Medical and/or Special Conditions:**

\_\_\_\_\_  
\_\_\_\_\_

**Allergies/Medications:**

\_\_\_\_\_  
\_\_\_\_\_

**Physician** \_\_\_\_\_ **Office Phone No.** \_\_\_\_\_