

**PLEASE RETURN WITHIN 3 DAYS AFTER SCHOOL BEGINS
CONSENT FOR TREATMENT**

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As parents or guardians of _____, I give consent and authorize, during the school year, for the representative of Cedar Bluffs Schools, to authorize any medical treatment, including any necessary surgery or hospitalization, for my above-named dependent (dependents), for any injury or illness of an emergency nature he/she (they) will incur while participating in any activities at and for Cedar Bluffs Schools by any physician and dentist licensed in Nebraska.

(I) agree to pay and assume all responsibility for all medical and hospital expenses and any services of an emergency nature, and charges for (my) dependent(s).

(I) acknowledge and agree that Cedar Bluffs Schools are not responsible for any medical hospital expenses and charges that are incurred in the medical treatment or hospitalization of our dependent(s).

(Family Physician)

(Physician's Phone Number)

(Insurance Company)