MEDICAL TREATMENT CONSENT

In consideration of the fact that _____ has been enrolled and entrusted to the care of HMS School for Children with Cerebral Palsy, I hereby grant permission for emergency treatment deemed necessary or advisable by the Medical Director/Director of Nursing Services/ Designee of HMS School. In the event of an emergency, I understand that every reasonable effort will be made to contact me or those individuals whom I have identified as emergency contacts when the School cannot reach the parent(s). I grant permission for his or her transfer in any emergency to such hospitals deemed advisable. I grant permission for the transportation of the child between any hospitals if such transportation is deemed advisable in connection with the emergency treatment referred to above. In the event of transport of student for medical treatment of any nature, it is the policy of HMS to send the student with relevant medical records, or to send such medical records as soon as practicable thereafter.

I also give my consent for HMS School nurses to administer non-prescription medications and/or treatments in a non-emergency situation deemed necessary or advisable by the Medical Director/ Director of Nursing Services/Designee to respond to changes in student health status (i.e., Tylenol for fever, or a suppository for constipation). I understand that I will be notified of those changes.

I recognize that HMS is an academic and not a medical facility and, as such, will not implement any "Do Not Attempt to Resuscitate" ("DNAR") orders. HMS considers adherence to a DNAR order to be a medical determination. I understand and acknowledge that I have been informed of this policy.

* Signature of Parent/ Guardian: _____ Date: _____

Relationship to Child _____

* Signature of Parent/Guardian: _____ Date: _____

Relationship to Child _____

* Witness: _____ Date: _____

* Required to be completed

DR 7/13