INFORMED CONSENT FOR MEDICAL TREATMENT

Name of Student _____ Date of Birth _____

Address _____

_____

1. ~~Physical condition~~ **Medical Diagnosis** for which the student procedure is to be performed

   _____

2. **Indication for procedure (symptoms to look for to initiate treatment)** _____

   _____

3. Name of standard procedure **and medication (including dosage) if applicable** _____

   _____

4. Precautions, possible reaction, and interventions _____

   _____

   _____

   _____

5. Time Schedule ~~and/or indication for procedure~~ **(indicate exact duration of treatment in days/months)** _____ _____

   _____

~~5. The procedure is to be continued as above until _____.~~

~~6. This procedure is to be performed/observed by _____.~~

_____ _____
Physician's Signature Physician's Telephone

_____
Date

I hereby request that the treatment specified above be performed to the above named child.