

**CHARLESTON COUNTY SCHOOL DISTRICT
EXTRACURRICULAR AND AFTER-HOURS SCHOOL-SPONSORED EVENTS AND TRIPS
CONSENT FOR MEDICAL TREATMENT 2009-2010**

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GENERAL INFORMATION

Student _____ **Home Phone ()** _____ **Cell Phone ()** _____

Address _____

City _____ **Zip** _____

Father's Name _____ **Home Phone ()** _____

Address _____
Street City State Zip Code

Place of Business _____ **Work Phone ()** _____ **Cell Phone ()** _____

Mother's Name _____ **Home Phone ()** _____

Address _____
Street City State Zip Code

Place of Business _____ **Work Phone ()** _____ **Cell Phone ()** _____
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ALTERNATE TO NOTIFY IN CASE OF EMERGENCY

NAME _____

Relationship _____ **Phone ()** _____

City _____ **State** _____ **Zip** _____
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FINANCIAL CONSIDERATIONS

For and in consideration of emergency services and goods rendered by or through the attending physician(s), the undersigned hereby guarantees payment in full, immediately upon receipt of the final billing.

SIGNATURE _____ **DATE** _____

