

School Term:

____20____

CMN Student ID #

College of Menominee Nation
Learn and Earn-Student Health Service

Consent for Treatment of Minor

Print Student Name _____ Date of Birth ____/____/____

Mailing Address _____

P.O. Box or Number/Street

City Zip Phone _____

Emergency Contact Person: _____

Phone Number: _____

Known Allergies: _____

Any diseases, illness, or other known condition: _____

I give permission for any and all medical treatment to be administered to my child in the event of an emergency situation under the direction of Staff/Faculty personnel at the College of Menominee Nation. I also assume the responsibility for the payment of any such treatment. This release is effective for the period of one year from the date given below.

As the parent/guardian of the above, I give my consent for emergency medical care prescribed by a licensed Physician.

Parent/Guardian Signature _____ **Date** ____/____/____

CONSENT FOR PHOTOGRAPH

I, _____ (Students name), give permission to use my name and/or photos in promotional publications, articles, or documents related to my participation in the "Learn and Earn/Youth Options" Programs and the College of Menominee Nation. I also understand this consent is effective for the period of one year from the date given below.

Student Signature _____ **Date** ____/____/____

Parent/Guardian Signature _____ **Date** ____/____/____