CARROLL COUNTY PUBLIC SCHOOLS
TREATMENT CONSENT FORM

Name: ____________________________ DOB: ____________________ Allergies: ____________________________ Grade/Teacher: ____________________

Treatment: ____________________________ Time(s): ____________________ From: ____________________ To: ____________________

(Orders apply for current school year to include summer programs, unless otherwise noted)

*Comments:
________________________________________

________________________________________

________________________________________

Parent/Guardian: ____________________________ / ____________________________ Date: ______________
Print Signature

Health Care Provider: ____________________________ / ____________________________ Date: ______________ Health Care Provider Phone #: ____________________________
Print Signature

MONTH 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
AUGUST
SEPTEMBER
OCTOBER
NOVEMBER
DECEMBER
JANUARY
FEBRUARY
MARCH
APRIL
MAY
JUNE
JULY

Codes: (chart reason)
A - Absent  F - Field Trip  O - No Show
C - School Closed  H - Holiday  W - Treatment Withheld
E - Early Dismissal  L - Late Opening

Initial Name Initial Name

Revised 07/22