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