MEDICAL CONSENT FORM

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, certify that I am a student attending BISD Adult Continuing Education, and as such, I hereby convey temporary authority to the instructor or administrator in charge for the sole purpose of obtaining or arranging any emergency medical care for myself in case of accident/illness as may be deemed necessary for my well-being.

*THEREFORE*, I hearby give consent to the instructor or administrator in charge with the authority to arrange and/or consent for any and all emergency medical care and treatment of myself as deemed necessary.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Student Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student Signature Name of Witness/Signature