CARROLL COUNTY PUBLIC SCHOOLS
TREATMENT CONSENT FORM

(PLEASE PRINT)

Name: ______________________________ DOB: ___________________ Allergies: ____________________________________ Grade/Teacher: __________________

Treatment: ____ Time: ___________________________From: ___________________ To: _____________________

Parent/Guardian Signature: ____

Physician Signature: ____ **Physician's Phone #** ____

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

Initial	Name	Initial	Name
______	_________________________	______	____________________________
______	_________________________	______	____________________________
______	_________________________	______	____________________________

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																															

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