

**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																															