

**ST. ANDREWS PRESCHOOL  
PARENT CONSENT TO TREAT A MINOR FORM**

Being the parent or legal guardian of \_\_\_\_\_, (minor's name printed)  
I \_\_\_\_\_ (parent/guardian's name printed) do consent to any x-ray, anesthetic, medical, surgical or dental diagnosis or treatment that may be deemed necessary for my minor child. Further, I understand that all efforts will be made to contact me prior to treatment. In the event I cannot be reached in an emergency, I give permission to the activity leader to make the decisions necessary for treatment. Should there be no activity leader available, I give permission to the attending physician to treat my minor child, I further understand that the doctors, dentists, and other providers attending to my child will take all reasonable safety precautions during their care.

Further, as parent or legal guardian I am responsible for the health care decisions for my minor child and agree that my insurance plan is the primary plan for the dental, medical, or hospital care or treatment that is given to my child. Any policy of the preschool will be used as the secondary coverage.

Minor's date of birth: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_