



SOUTH DAKOTA
FFA ASSOCIATION

CONSENT FOR MEDICAL TREATMENT FORM

Student Name: _____ Date of Birth: _____

The South Dakota FFA Association recommends that all member schools receive consent from all students and parent/guardians prior to activities, to ensure that medical care can be provided to the student during any activity away from home. This form should be kept both on file at the school, as well as in the possession of a student's FFA Advisor authorizing as below:

CONSENT FOR MEDICAL TREATMENT (for those children 18 and under at any time during the _____ school year):

I, _____, am the (circle one) Parent or Legal Guardian, of ,
_____ who participates in FFA for
_____ School. I hereby consent to any medical services that may be required while said child is under the supervision of an employee of the fore-mentioned high school while on an FFA activity, and hereby appoint said employee to act on behalf of myself in securing medical services from any duly licensed medical provider.

Signature of Parent

Date

CONSENT OF PARTICIPANT (for all students to complete):

I, _____, have read the above consent for medical treatment form signed above, or, as an individual of majority age, consent to those same medical services and actions as indicated above on this form.

Signature of Student

Date