



**Thunderbird Adventist Academy**  
 7410 E. Sutton Drive, Scottsdale, AZ 85260



Phone: 480-948-3300 • Fax: 480-443-4944 • www.thunderbirdacademy.org

Only designated staff will have access to the completed form. This form will be stored in a locked file.

Student's Full Name \_\_\_\_\_

Birthdate: (MM/DD/YYYY) \_\_\_\_\_ Sex:  Male  Female Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Name of Mother/Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell/Pager Phone: \_\_\_\_\_

Name of Father/Guardian: \_\_\_\_\_ Home Phone: \_\_\_\_\_ Cell/Pager Phone: \_\_\_\_\_

Mother's Business Phone: \_\_\_\_\_ Father's Business Phone: \_\_\_\_\_

Alternate Person to Notify: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Any known allergies: \_\_\_\_\_ Date of Last Tetanus Shot: \_\_\_\_\_

Pertinent History (ex. Diabetes, asthma, heart problems, etc.): \_\_\_\_\_

Medications taken regularly: \_\_\_\_\_

Person Prescribing Medication: \_\_\_\_\_  
Name Phone

\_\_\_\_\_ Address City State ZIP

Name of Insurance Company: \_\_\_\_\_ Group Number: \_\_\_\_\_

For the following complaints, my preference of treatment:

**Headache:**  Herbal (white willow bark, feverfew, etc)  Acetaminophen(Tylenol)  Ibuprofen (advil,motrin)  Other \_\_\_\_\_

**Stomach complaints:**  Charcoal  Antacids  Pepto-Bismol  Other \_\_\_\_\_

**Generalized Pain:**  Herbal (white willow bark, feverfew, etc)  Acetaminophen(Tylenol)  Ibuprofen (advil,motrin)  Other \_\_\_\_\_

In the event that an accident occurs or a medical problem arises in which my child must receive immediate treatment while at school or on a school-sponsored trip, I, the undersigned parent /guardian of the above minor, do hereby consent to any X-ray examination, immunization, anesthetic, medical, or surgical diagnosis or treatment and hospital service that may be required to aid the minor under the general or specific instruction of a physician.

It is further understood that this consent is given in advance of any specific diagnosis or treatment that might be required and is given to authorize Thunderbird Adventist Academy or the physician to exercise their best judgment as to the requirements of such diagnosis or treatment.

I hereby authorize any hospital, physician, or other person who has attended or examined the minor to furnish the insurance service, or its representative, any and all information with respect to any illness, medical history, consultation, prescription or treatment, and copies of all hospital or medical records. This authorization is given pursuant to the local state Civil Code. This consent shall remain in continuous effect until revoked in writing. A photocopy of this authorization shall be considered as effective and valid as the original.

The signing of this form shall include authorization for immunization and/or injections for prevention of disease as required for schools in Maricopa County, Arizona.

Parent/Guardian Name (Please Print) \_\_\_\_\_

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness Signature \_\_\_\_\_ Date \_\_\_\_\_

**PLEASE ATTACH COPY OF INSURANCE INFORMATION**  
**SCHOOL INSURANCE IS A SECONDARY ACCIDENT INSURANCE – NOT HEALTH INSURANCE**