



Emergency Medical Treatment Consent Form

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 _____

Home Address: _____

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: _____

Table with 4 columns: Name, Address, City, State, ZIP, Phone, Group Number. Includes fields for Name, Phone, Address, City, State, ZIP, and Group Number.

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