Thunderbird
Adventist Academy
CONSENT TO TREATMENT

Only designated staff, such as the school nurse or physician, will have access to the completed form.

Student Full Legal Name _____ Date of Birth _____
Mo. Day Yr.

Address _____ _____ _____
Number & Street State Zipcode

Parent/Guardian's Names _____

Father/Guardian Business Phone _____ Home Phone _____

Mother/Guardian Business Phone _____ Home Phone _____

Please describe allergies to substances and medication _____

_____

If on regular medication, please specify _____

Date of last tetanus shot _____

Please give the name of your local family physician(s) to be called in case your son or daughter becomes ill or has an accident at school and you cannot be reached.

1. Family Physician _____ Office Phone _____

Address _____

2. Family Physician _____ Office Phone _____

Address _____

Hospital Preference _____ Telephone _____

Please give the names of two relatives or friends who have consented to assume the responsibility of your son or daughter in case of illness or accident until you can be reached. In case of any changes in the named persons, notify the school in writing.

1. Name _____ Telephone _____

Address _____

2. Name _____ Telephone _____

Address _____

If emergency service involving medical action or treatment is required and neither the parent/guardian nor the family physician can be reached for consent, the parent/guardian hereby consents to the rendering of such emergency medical service for the above named student as shall be necessary in the medical opinion of the doctor rendering the service. This authorization is given pursuant to the local state Civil Code.

Signature of Parent or Guardian _____ Date _____