

Consent to Treatment

Blackberry Seventh-day Adventist School

Student's Full Name: _____

Age _____ Date of Birth _____ Social Security Number _____

Address: _____

Parent/Guardian Information:

Name: _____ Relation: _____

Home: _____ Work: _____ Mobile: _____ SS#: _____

Email: _____

Name: _____ Relation: _____

Home: _____ Work: _____ Mobile: _____ SS#: _____

Email: _____

Please describe allergies to substances and medications: _____

Medications child is taking: _____ Date of Last Tetanus Shot: _____

Any known medical conditions: _____

Local Family Physician:

Physician Name _____ Phone: _____

Physician's Office Address: _____

Hospital Preference: _____ Phone: _____

Please give the name of a relative or friend who has consented to assume the responsibility of your child in case of illness or accident until you can be reached. In case of any changes in the named person, notify the school in writing.

Name: _____ Phone: _____

Address: _____

The above named student **is / is not** (circle one) covered by health insurance.

Company _____ Policy #: _____

If emergency service involving medical action or treatment is required and neither the parent nor the family physician can be reached for consent, the parents hereby consent 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 service.

Parent/Guardian _____ Date: _____