



Consent to Treatment Colquitt Christian Academy

2018-2019 School Year

Only designated staff will have access to the completed form. This form will be stored in a locked file. This form must be filled out at the beginning of each school year to cover the activities for that school year. A copy of each student's form will accompany the student on any off-campus activities.

Student's Full Name _____

Age _____ Date of Birth (month/day/year) _____ Social Security Number (United States) _____

Address:

Parent/Guardian Information:

Father/Guardian _____

Business Phone _____ Home Phone _____ Cell Phone _____ Social Security Number _____

Mother/Guardian _____

Business Phone _____ Home Phone _____ Cell Phone _____ Social Security Number _____

Please describe any known allergies to substances and/or medications: _____

If on regular medication, please specify: _____
Date of last Tetanus Shot _____

Please give the name of your local family physician to be called in case your child becomes ill or has an accident and you cannot be reached:

Family Physician's Name _____ Office Phone _____

Hospital Preference: _____
Hospital 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, you must notify the school in writing.

Name: _____
Phone Number _____

Address: _____

The above named student is _____ is not _____ covered by health insurance.

Present Health Insurance Company _____ Policy Number _____

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.

Signature of Parent or Guardian _____ Date _____