

# Pacific Union Conference CONSENT TO TREATMENT

Only designated staff, such as the school nurse or physician, 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 the school year. A copy of each student's form must be taken on off-campus activities.*

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

Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
mo. day yr.

Address \_\_\_\_\_

Parent/Guardian's Name \_\_\_\_\_

Father/Guardian \_\_\_\_\_  
Business Telephone Home Telephone

Mother/Guardian \_\_\_\_\_  
Business Telephone Home Telephone

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 Telephone \_\_\_\_\_

Address \_\_\_\_\_

2. Family Physician \_\_\_\_\_ Office Telephone \_\_\_\_\_

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 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 the service. This authorization is given pursuant to the local state Civil Code.

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_