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_____ Social Security Number_____
mo. day yr.

Address _____

Parent/Guardian's Name_____

Father/Guardian _____ _____ _____
Business Telephone Home Telephone Social Security Number

Mother/Guardian _____ _____ _____
Business Telephone Home Telephone Social Security Number

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:_____

WHITE – File Copy YELLOW – Off–Campus Activity Copy