Pacific Union Conference
Consent to Treatment

Student's Name_____

Age_____ Date of Birth _____Social Security_____
Mo. Day Year

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 name of your local family physician to be called in case your son or daughter become ill or has an accident at the school and you cannot be reached.

Family Physician_____ Office Telephone_____

Address_____

Hospital preference_____ Telephone_____

Please give the name 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 change in the named person, notify the school in writing.

Name _____ Telephone_____

Name _____ Telephone_____

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 student as shall be necessary in the medical opinion of the doctor rendering service. This authorization is given pursuant to local state Civil Code.

Signature of Parent or Guardian_____ Date _____