## 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 Name	
Age Date of Birth Mo. Day Yr.	
Address	
Parent/Guardian's Name	
Father/Guardian Business Phone	
Mother/Guardian Business Phone	Home Phone
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 sc school and you cannot be reached.	on or daughter becomes ill or has an accident at
1. Family Physician	Office Phone
Address	
2. Family Physician	Office Phone
Address	
Hospital Preference	
Please give the names of two relatives or friends who have consented to assume illness or accident until you can be reached. In case of any changes in the named	. , ,
1. Name	Telephone
Address	
2. Name	Telephone
Address	
If emergency service involving medical action or treatment is required and neither the parent/guardian nor the family physician can be reached for consent, the parent/guardian hereby consents 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