

Pacific Union College Preparatory School

CONSENT TO TREATMENT

Student Name: _____

Age: _____ Date of Birth: _____ Social Security Number: _____

Address: _____

Parent/Guardian Name: _____

Father/Guardian:

_____ Business Telephone

_____ Home Telephone

_____ Social Security Number

Mother/Guardian:

_____ Business Telephone

_____ Home Telephone

_____ Social Security Number

Please describe allergies to medications and substances:

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 child becomes ill or has an accident at school and you cannot be reached:

Physician Name Telephone Office Address

Physician Name Telephone Office Address

Hospital Preference

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.

Name Address Phone

Name Address Phone

If emergency service involved 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.

Parent Signature

Date