Southwest Region Conference of SDA
CONSENT TO TREATMENT

Student's Name _____
Last First Middle

Date of Birth: _____Sex: Male _____ Female _____ Age _____ Student's S.S.#: _____-_____-_____

Address: _____

Mother: _____ **Father:** _____

Guardian: _____

Please describe allergies:

Date of last tetanus shot:

Please give the name of your local family medical information in case your son or daughter becomes ill or has an accident at school and you cannot be reached.

Physician's Name: Telephone Number:

Address: _____

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 name persons, notify the school in writing.

Name: _____ Telephone Number: _____

Address: _____

Name: _____ Telephone Number: _____

Address: _____

If emergency service involving medical action or treatment is required and neither 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.

_____ _____ _____
Print Name Signature Date