CONSENT TO TREATMENT

***Only designated staff will have access to this 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 this form will be taken on all off-campus activities.

Student’s Name

Age \_\_\_\_\_\_\_\_\_ Date of Birth Social Security Number

MONTH/DAY/YEAR

Address

NUMBER STREET (PO BOX) CITY STATE ZIP CODE

Parent/Guardian’s Name

Father/Guardian

HOME PHONE WORK PHONE CELL PHONE

Mother/Guardian

HOME PHONE WORK PHONE CELL PHONE

Please describe allergies to substances and medications

Date of last Tetanus Shot

In the event that your child has to take prescribed medication or frequent doses of over-the-counter drugs please send the medication in the original container, plainly marked with your child’s name and dispensing directions, to the teacher. Please check permissions below to dispense over-the-counter drugs.

**Tylenol: Yes  No  Ibuprofen: Yes  No **

Physician’s Name Office Telephone

Dentist’s Name Office Telephone

Hospital preference Telephone

Please give the names of two relatives or friends who have consented to assume the responsibility of your child in case of illness or accident until you can be reached. (In the event of any changes in the named persons, notify the school in writing.)

1. Name Telephone

2. Name Telephone

If emergency service involving medical action or treatment is required and a parent or guardian cannot be reached for consent, I hereby consent to the rendering of such emergency medical services for the above-named student as shall be deemed necessary in the opinion of the doctor rendering the service. This authorization is given pursuant to the local State Civil Code.

PARENT/GUARDIAN SIGNATURE

DATE

Hot Springs Adventist School, 401 Weston Road, Hot Springs, AR 71913