Middletown Adventist School

Consent to Treatment

Please complete one form per child.

Name of child enrolled in school	Date of Birth	Describe any allergies to substances and/or medications	Date of Last Tetanus

Physical address:

Mailing address:

Parent/Guardians' name(s): _____

Father/Guardian:				
	business telephone	home telephone	cell phone	email address
Mother/Guardian:				
	business telephone	home telephone	cell phone	email address

Please give the name of your local family physician to be called in case your child becomes ill or has an accident at school and you cannot be reached.

Family physician:		**Office telephone:**	

Clinic address:	

Hospital preference:	

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

Name #1:		**Telephone**:	

Address:	

Name #2:		**Telephone**:	

Address:	

If an emergency service involving medical action or treatment is required and neither the parent nor family physicians 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 physician rendering the service. This authorization is given pursuant to the California State Civil Code.

Parent's signature: _____ **Date:** _____