

**Southwestern Union Conference
Consent to Treatment Authorization
2018-2019**

This form must be filled out at the beginning of each school year to cover the activities for the school year and must be taken on off-campus activities. Only designated staff will have access to the completed form.

Student's Name: _____

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

Address: _____

Father (Guardian): _____

Address: _____

Cell Phone: _____ Home Phone: _____

Mother (Guardian): _____

Address: _____

Cell Phone: _____ Home Phone: _____

Medical Information

Date of last tetanus shot: _____ Allergies to Medications: _____

Chronic Medial Problems: _____

Current Medications: _____

Physician information

Please give the name of your local family physician(s) to be called in case your son or daughter becomes ill or has an accident at school and you cannot be reached

Family Physician: _____ Phone # _____

Address: _____

Hospital Preference: _____ Phone # _____

Please give the names of two persons who have consented to assume the responsibility of your child 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: _____

Cell Phone: _____ Home Phone: _____

Name: _____

Cell Phone: _____ Home Phone: _____

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: _____ Date: _____

Parent/Guardian Signature: _____