Student Name: _____ NAD ID#_____*(office use only)*

CONSENT TO TREATMENT

(Only designated staff, school nurse or physician, will have access to the complete form. This form will be stored in a locked file. A copy of each student's form must be taken on off campus activities in case of an emergency.)

Today's Date: _____/_____/_____ **SSN:** _____-_____-_____ ☐ **Male** ☐ **Female**

Student's Residential Address: _____
Street Apt./Lot

_____
City State Zip

Date of Birth: _____/_____/_____ Age _____ Approx. Weight _____ Height _____

Is your student covered by health insurance? ☐ Yes ☐ No Coverage Effective

_____

Primary Health Insurance Company _____

Policy Number _____ Subscriber's Name _____

PARENT/GUARDIAN INFORMATION

Name		Name	
Relationship		Relationship	
Home Phone		Home Phone	
Cell Phone		Cell Phone	
Work Phone		Work Phone	
E-mail		E-mail	

List 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 case of any change in the named person, notify the school in writing.

1. _____
Name Phone Number Relationship

2. _____
Name Phone Number Relationship

In case of emergency, accident, or serious illness, if the school is unable to contact me, I hereby authorize the school to take my child to the physician, emergency room, and/or to the relative or family friend indicated.

Physician's Name: _____ Phone Number: _____

Address _____ City _____ State _____ Zip _____

Hospital Preference _____

Please describe **ALL ALLERGIES** to substances and medication: _____

_____

If student takes regular *medication, please specify: _____

*Medication to be taken at school requires a completed Medical Admission Information.

If emergency service involving medical attention or treatment is required and neither parents nor the family physician can be reached for consents, 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 service.

Signature of Parent/Guardian _____

Print Name _____ Date _____