Adventist Education
A JOURNEY TO EXCELLENCE

SIMI VALLEY ADVENTIST SCHOOL

1636 Sinaloa Rd., Simi Valley, CA 93065 * Ph. 805-583-1866 * Fax 805-526-7657 * svas1636@yahoo.com

CONSENT TO TREATMENT

Only designated staff, such as the school nurse or physician, will have access to the 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 each student's form must be taken on off-campus activities.

Student's Name ______________________________________Age ____Date of Birth __________

Address ____

Father/Guardian Name ____

____
Business Telephone Home Telephone Cell Phone

Mother/Guardian Name ____

____
Business Telephone Home Telephone Cell Phone

Any Allergies to Substances and/or Medications ____

List Any Regular Medications ____

Date of Last Tetanus Shot _______________

Family Physician ______________________________Office Telephone _____________________

Hospital Preference ___________________________Telephone ___________________________

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 named persons, notify the school in writing.

1. Name ____Telephone ____________________

2. Name ____Telephone ____________________

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

_____________________________________ _____________________________________
Parent/Guardian Signature *Date*