CONSENT TO TREATMENT

Rocky Mountain Conference
School System

Student's Name: ______________________________ School: Spring Creek Adventist School

Address: ____________________________________

____

Business Phone: Father___________________ Mother_____________________

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

Family Physician: ____________________________ Secondary Physician: _______________

Office Phone: ________________________________ Office Phone: ______________________

Address: ____________________________________ Address: ___________________________

____ __________________________________

Hospital Preference: ____

Please give the names of two (2) 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 changes in the named persons, notify the school in writing.***

Name: _______________________________ Name: _______________________________

Phone: _______________________________ Phone: _______________________________

Address: _____________________________ Address: _____________________________

_____________________________________ _____________________________________

If emergency services involving medical action and treatment is require and neither the parent nor the family physician can be reached for consent, the parent hereby consents to the rendering of such emergency medical services for the above-named child if it becomes necessary in the medical opinion of the doctor rendering such services

____
Parent Signature:

____
Date: