



NORTHERN CALIFORNIA CONFERENCE

CONSENT TO TREATMENT

AND

AUTHORIZED STUDENT RELEASE FORM EL DORADO ADVENTIST SCHOOL

Student Name _____ **Grade** _____ **Age** _____ **DOB** _____

Address _____

Father/Guardian _____
Name _____ Business Phone _____ Home Phone _____

Mother/Guardian _____
Name _____ Business Phone _____ Home Phone _____

Cell Phone/Pager #'s _____
Mother _____ Father _____

Email: _____
Mother _____ Father _____ Student _____

ALLERGIES (medication/environmental/foods) _____

Daily Medications (strength & dosage) _____

Special Medical Concerns/Diagnosis (i.e., diabetic) _____ **Date of last Tetanus Shot** _____

Medical Insurance _____ **Subscriber ID #** _____ **Group #** _____

1. Family Physician _____ **Phone** _____

2. Family Physician _____ **Phone** _____

Please give names of relatives or friends who have consented to assume the responsibility of your son or daughter in case of illness, accident, or in the event of a major disaster____(if more room is needed – please use the back of this form)

1. Name _____ Address _____ Relationship _____

Home Phone _____ Work Phone _____ Cell/Pager _____

2. Name _____ Address _____ Relationship _____

Home Phone _____ Work Phone _____ Cell/Pager _____

3. Name _____ Address _____ Relationship _____

Home Phone _____ Work Phone _____ Cell/Pager _____

If emergency service involving medical action/treatment is required and neither parent nor 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 physician rendering the service. This authorization is given pursuant to the local state Civil Code.

Parent/Guardian Signature _____ Date _____

NOTE: If there are Child Custody/Restraint issues regarding your student, please submit a copy of the court order.