

# Skagit Adventist Academy

## Consent to Medical Care and Treatment

### 2023-2024

In the event that I am not readily available, I consent to all medical, surgical, diagnostic, and hospital procedures as may be performed or prescribed by a physician for

\_\_\_\_\_ Child's Name \_\_\_\_\_

When such treatment is deemed immediately necessary or advisable by a physician to safeguard my child's health, I waive my right to informed consent for treatment.

\_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ Signature of parent/guardian \_\_\_\_\_

\_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_\_\_ Parent/guardian printed name \_\_\_\_\_

**Completely fill out this form. If something does not apply, please write N/A.**

<b>Child's Information</b>	<b>Birth Date:</b>
Date of last Tetanus shot:	
Regular Medications:	
Allergies:	
Drug Reactions:	
Other Health Information:	
Physician's Name & Phone:	
Hospital Preference:	
Insurance Name and #	
<input type="checkbox"/> Do not have insurance coverage	

**Parent Information**

Mother's Work Phone \_\_\_\_\_ Father's Work Phone \_\_\_\_\_

Hours \_\_\_\_\_ Hours \_\_\_\_\_

Mother's Cell Phone \_\_\_\_\_ Father's Cell phone \_\_\_\_\_

**OTHER EMERGENCY CONTACT** \_\_\_\_\_

Name Relationship

Phone \_\_\_\_\_

**Please attach copy of both sides of health insurance card**