# Skagit Adventist Academy

## Consent to Medical Care and Treatment
## 2024-2025

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.**

| **Child's Information** | Birth Date: |
|---|---|
| Date of last Tetanus shot: | |
| Regular Medications: | |
| Allergies: | |
| Drug Reactions: | |
| Other Health Information: | |
| Physician's Name & Phone: | |
| Hospital Preference: | |
| Insurance Name and # | |
| ☐ 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***