West Covina Hills Adventist School

3528 E Temple Way
West Covina, CA 91791
(626(859-5005
www.westcovinahills.org

CONSENT TO TREATMENT

PACIFIC UNION CONFERENCE

Student's Name (First - Middle - Last)	DOB	AGE	Grade:
Address			
Parent/Guardian 1: Name	Phone		
Parent/Guardian 2: Name	Phone		
Known Allergies	If on regular medication, please specify	Date of Last Tetanus Shot	

Please give the name of your local family physician(s) to be called in case your child becomes ill or has an accident at school and you cannot be reaches.

Doctor's Name	Phone
Address	
Hospital Preference	Phone

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 person, notify the school in writing.

Name 1.	Phone
Address	
Name 2.	Phone
Address	

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 opiniobn of the doctor rendering the service. This authorization is given pursuant to the local state Civil Code.

Signature of Parent or Guardian:	Print Name:	Date: