NAD ID#	(office use only)
	NAD ID#



CONSENT TO TREATMENT

(Only designated staff, school nurse or physician, will have access to the complete form. This form will be stored in a locked file. A copy of each student's form must be taken on off campus activities in case of an emergency.)

Date of Birth:/ Age Is student covered by health insurance? Yes Primary Health Insurance Company Policy Number	<u> </u>	
City S Date of Birth:/ Age Is student covered by health insurance? □ Yes Primary Health Insurance Company Policy Number PARENT/GUARDIAN INFORMATION Name Relationship		
Date of Birth:/ Age Is student covered by health insurance? □ Yes Primary Health Insurance Company Policy Number PARENT/GUARDIAN INFORMATION Name Relationship		Apt./Lot
Is student covered by health insurance? Primary Health Insurance Company Policy Number PARENT/GUARDIAN INFORMATION Name Relationship	tate	Zip
Primary Health Insurance Company Policy Number PARENT/GUARDIAN INFORMATION Name Relationship	Approx. Weight	Height
Policy Number	□ No Coverage Effe	ective
PARENT/GUARDIAN INFORMATION Name Relationship	_	
Name Relationship	Subscriber's Name	
Relationship		
*	Name	
Home Phone	Relationship	
	Home Phone	
Cell Phone	Cell Phone	
Work Phone	Work Phone	
E-mail	E-mail	
List the names of two relatives or friends who be illness or accident until you can be reached. In writing. 1		
2		
Name In case of emergency, accident, or serious illness, take my child to the physician, emergency room, a		
	Phone Number:	
Address		
Hospital Preference Please describe ALL ALLERGIES to substa	nces and medication:	
If student takes regular *medication, please sp *Medication to be taken at school requires a completed Medi		
If emergency service involving medical attention of the reached for consents, the parents hereby conse name student as shall be necessary in the medical	nt to the rendering of such eme	rgency medical service for the above-
Signature of Parent/Guardian Print Name		Pate