THE OAKS ADVENTIST CHRISTIAN SCHOOL
Emergency Consent Form

We, the undersigned parents/guardians of _____, a minor, do hereby appoint The Oaks Adventist Christian School as our representative for authorizing and consenting to medical care and treatment of any illness or injury that may occur while out child is in their custody between the dates of August 1, 2019 and May 31, 2020.

Is the above named student covered by health insurance? Yes ☐ No ☐

Insurance Company Name _____ Policy Number _____

Name of Primary Insured _____ Group Number _____

Student's Full Legal Name	Date of Birth	Social Security Number	Date of Last Tetanus Shot	
Student's Home Address		City	State	Zip Code
FATHER'S INFORMATION Name	Address	City	State	Zip Code
Place of Employment	Cell Phone	Work Pone		
MOTHER'S INFORMATION Name	Address	City	State	Zip Code
Place of Employment	Cell Phone	Work Phone		
Emergency Contact Name	Cell Hone	Relationship		
Emergency Contact Name	Cell Phone	Relationship		

MEDICAL HISTORY (Please write n/a if not applicable to your child.

Please list any allergies to drugs (especially anesthetics or penicillin) and or foods. _____

Has your child had any of the following? (Check all that apply)

____ Convulsions ____ Heart Ailment ____ Kidney Ailment ____Diabetes ____ Epilepsy ____ Bronchitis ____ Asthma ____ Tuberculosis ____ Depression

Please list all medications that your student is currently taking: _____

Please list all surgeries your child has had _____

Please list ALL other pertinent medical information that may be needed in an emergency: _____

_____

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event that a parent and/or Emergency Contact cannot be reached, I, the undersigned, do herby authorize officials of The Oaks Adventist Christian School to take whatever action is deemed necessary, in their judgment, for the health of aforesaid child.

If emergency service involving medical action or treatment is required, and parents or guardians cannot 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 doctor rendering service. The authorization is given in pursuant to the local state Civil Code.

Signature of Parent or Legal Guardian _____ Relationship _____

Family Physician _____ Phone _____