Southeastern California Conference Office of Education
Student Consent to Treatment Form
For School Year 2010-2011

Student Information	Last Name	First Name	Middle Initial		Date of Birth (Mo/Day/Yr)	
	Street Address	City	State	Zip	Sex (M, F)	Phone

Student Medical Information	Please describe allergies to substances and medication (if none, please write "NONE")
	If on regular medication, please specify:
	Any medical conditions (i.e. Asthma):

Parent/Guardian Information:

Primary Parent/Guardian At above address	Last Name	First Name	Work Phone	Cell Phone
Secondary Parent/Guardian At above address	Last Name	First Name	Work Phone	Cell Phone

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

Family Physician	Name	Office Phone
	Address	
Family Physician	Name	Office Phone
	Address	
Hospital Preference		

Please give the names of two relatives or friends who have consented to assume the responsibility of your son or daughter in case of illness or accident until you can be reached. In case of any changes in the named persons, please notify the school in writing.

Name	Home Phone	Cell Phone
Name	Home Phone	Cell Phone

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/guardians 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.

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Signature of Parent/Guardian Date