



**LA SIERRA ACADEMY JUNIOR HIGH**  
*Courage, Excellence, Faith, Honor, Justice, Truth*

**CONSENT TO TREATMENT**  
**2009-2010**

PLEASE PRINT LEGIBLY OR TYPE

**Student Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_/\_\_\_/\_\_\_ **Grade:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

**FATHER/GUARDIAN**

(Please print)

**Parent Name:** \_\_\_\_\_ **Place of Employment:** \_\_\_\_\_

**Work Phone:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

**MOTHER/GUARDIAN**

**Parent Name:** \_\_\_\_\_ **Place of Employment:** \_\_\_\_\_

**Work Phone:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Cell Phone:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

**EMERGENCY INFORMATION**

Please describe allergies to substance and medication. (If none, please write, "NONE")

**Date of Last Tetanus shot:** \_\_\_/\_\_\_/\_\_\_ **Medications, please specify** \_\_\_\_\_

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

**1. Family Physician:** \_\_\_\_\_ **Office Telephone:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Hospital Preference:** \_\_\_\_\_

**2. Family Physician:** \_\_\_\_\_ **Office Telephone:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Hospital Preference:** \_\_\_\_\_

**AUTHORIZED STUDENT RELEASE INFORMATION**

After school, and/or in the event your student needs to be sent home (accident, illness, disaster), please list authorized individuals over 18 to whom your student may be released. I.D. may be required. Any adjustments to authorized names must be submitted in writing. Additional names may be written on the reverse side of this form.

(Please print)

**1. Name:** \_\_\_\_\_ **Home Telephone:** \_\_\_\_\_

**2. Name:** \_\_\_\_\_ **Home Telephone:** \_\_\_\_\_

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

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**DATE**

**SIGNATURE OF PARENT/GUARDIAN**