Victor Valley Seventh-day Adventist School
Where Excellent Education and Core Christian Concepts Meet
17137 Crestview Drive, Victorville, CA 92395 (760) 243-4176 Fax: (760) 245-5606 vvsda.com

STUDENT CONSENT TO TREATMENT FOR SCHOOL YEAR 2012 - 2013

Student's Name _____D.O.B_____

Address _____

Home Phone _____ Cell _____

Father/Guardian _____ Bus Phone _____

Mother/Guardian _____ Bus Phone _____

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

_____

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 son or daughter becomes ill or has an accident at school and you cannot be reached.

1. Family Physician _____ Office Phone _____

Address _____

2. Family Physician _____ Office Phone _____

Address _____

3. 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, notify the school in writing.

1. Name _____ Phone _____

Address _____

2. Name _____ 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 opinion of the doctor rendering service.

Parent/Guardian Signature_____ Date_____