

KITSAP ADVENTIST CHRISTIAN SCHOOL **A2**

Consent for Treatment 2023-2024

I hereby grant Kitsap Adventist Christian School permission to seek medical attention for my child, _____, in the event of an emergency, if the school cannot contact me. I further consent to medical or surgical treatment by any licensed physician and/or hospital. I also permit administration of necessary anesthetics, medical treatment, tests, transfusions, injections, or drugs, and the performing of whatever operation may be necessary or advisable.

Parent/Guardian Signature _____ **Date** _____

MEDICAL/EMERGENCY INFORMATION

Last Name _____ First Name _____ Middle Name _____

Birth Date _____ Contact Phone _____

Preferred Doctor _____ Phone Number _____

Preferred Hospital _____ Phone Number _____

Insurance Provider _____

Group # _____ Membership # _____

Allergies _____

Health Problems _____

EMERGENCY RELEASE PHONE NUMBERS

The school personnel are authorized to release my child to the following people in case of an emergency, such as a medical issue, snowstorm, earthquake, or other natural disaster:

Name _____ Home Phone _____

Work Phone _____

Name _____ Home Phone _____

Work Phone _____

Name _____ Home Phone _____

Work Phone _____

Parent/Guardian Signature _____ **Date** _____