Sunnydale Adventist Academy

6818 Audrain Rd 9139, Centralia, MO 65240-9401 ♦ 573-682-2164

MEDICAL INFORMATION and CONSENT FORM

Student name: ______________________________ Birth date: ____/_____/____ Sex: M F Soc Security # ________________

Address: ________________________ City: ___________________State: _____ Zip: __________Home Phone: ________________

Mother name: ____ Cell Phone: ______________________

Father name: ____ Cell Phone: ______________________

Emergency contact not living with parent/guardian: Name: ________________________________ Phone: _____________________

Health Insurance ? Yes ? No Company Name: ___________________________ Name of Insured: ______________________

Insured Social Security Number (if other than student): ____

Policy # _____________________ Group # _______________________ Phone # ____

CONSENT TO HEALTH CARE/TREATMENT

	(initial each item)
The parent(s) of the above named student at SAA consent to any X-ray, anesthetic, medical or surgical evaluation or treatment and/or hospital service that may be rendered to said student under the general or special instructions of any licensed practitioner. If the situation is not an emergency, the parent/guardian will be called for verbal consent before proceeding with medical care/evaluation.	
I/We authorize any hospital, physician, or other person who has attended or examined the minor to furnish the General Conference Insurance Service, or its representative, any and all information with respect to any illness, medical history, consultation, prescriptions or treatment, and copies of all hospital and medical records.	
I/We consent to the administration of over the counter medications by staff/school nurse and prescription medication ordered by a licensed medical professional responsible for the student's care. **(If this area is not signed – your student needs to understand that the parent or guardian must be called whenever there is any need for medication.)** Medication Information: The school keeps common OTC medications available for students. Medication list is available upon request.	

MEDICATION MY STUDENT MAY NOT HAVE: Please list any medications your child may not receive-

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Medications My Student is Allergic to: ____

By signing below, I certify all health information provided is true and correct to the best of my knowledge. I agree to notify the school of any changes in the student health/health information when it occurs.

Date _________________________ Parent/Guardian Signature ____

All information is kept confidential and will only be made available to appropriate staff and medical care providers.

A copy of this authorization shall be as effective and valid as the original. This consent shall remain in continuous effect until revoked in writing and delivered to SAA

Updated 01/04/23