2017-2018

SAN GABRIEL ACADEMY
MEDICAL CONSENT TO TREATMENT

8827 E. Broadway. San Gabriel, CA 91776 (626) 292-1156 www.sangabrielacademy.org

Incomplete applications will not be accepted.

STUDENT INFORMATION			
Last Name	First	Middle	Name Used
Address (Street and PO Box)	City	State	Zip
Birthdate (MM/DD/YYYY)	Age		

PARENT/GUARDIAN INFORMATION		
Parent/Guardian Last Name	First	Relationship
Home Telephone	Work Telephone	Cellular

STUDENT'S HEALTH INFORMATION
List Any Medical Conditions (e.g. Asthma, Diabetes)
List Any Allergies (e.g. Medication, Food)
Prescription Medication(s)
Date of Last Tetanus Shot

STUDENT'S MEDICAL CARE INFORMATION			
Physician Full Name			Telephone
Address (Street and PO Box)	City	State	Zip
Hospital Preference			
Medical Insurance? ☐Yes ☐No	Policy Number		
Insurance Company	Phone Number		

STUDENT'S CONTACT OTHER THAN A PARENT/GUARDIAN		
Full Name		Relationship
Home Telephone	Work Telephone	Cellular

STUDENT'S OUT OF STATE CONTACT		
Full Name		Relationship
Home Telephone	Work Telephone	Cellular

If emergency medical or dental care and treatment is required and neither parent or guardian can be reached, I give the sponsor/agents from San Gabriel Academy School permission to act in our behalf to obtain required diagnosis, treatment, and/or hospitalization that is recommended by the physician/dentist. Consent is hereby given to physicians and dentists to perform required emergency diagnoses and treatment, including administering medications and surgical procedures deemed necessary.

Signature _____ Date _____