



11431 University City Blvd, Charlotte, NC 28213 · enrollment@cornerstoneadventistacademy.org

CONSENT TO TREATMENT

This form must be filled out at the beginning of each school year to cover the activities for the school year. A copy of each student's form must be taken on off-campus activities.

Student's Name _____ Age ____ Date of Birth _____

Address _____

Father/Guardian Name _____

Business Telephone _____ Home Telephone _____ Cell Phone _____

Mother/Guardian Name _____

Business Telephone _____ Home Telephone _____ Cell Phone _____

Any Allergies to Food and/or Medications _____

List Any Regular Medications _____

Date of Last Tetanus Shot _____

Family Physician _____ Office Telephone _____

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 _____ Telephone _____

2. Name _____ 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.

Parent/Guardian Signature

Date