Sunnydale Adventist Academy

6818 Audrain Rd 9139, Centralia, MO 65240-9401 ♦ 573-682-2164 ♦ Fax: 573-682-3136

MEDICAL INFORMATION and CONSENT FORM

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

Address: _____ City: _____State: _____ Zip: _____Home Phone: _____

Mother name: _____ Occupation: _____ Work Phone: _____

Father name: _____ Occupation: _____ Work Phone: _____

Emergency contact not living with parent/guardian: Name: _____ Phone: _____

Health Insurance □ Yes □ No Company Name: _____ Name of Insured: _____

Policy # _____ Group # _____ Phone # _____

Special Insurance Instruction: _____

HEALTH INFORMATION **List any pertinent medical/psychological information**: _____

_____

_____

Known Drug Allergies _____ Current Medications/Dosage _____

Physician _____ 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 available for students. Medication list is available upon request.	
I/We consent to head lice screening or drug screening as the administration deems necessary.	

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.

Date _____ Parent/Guardian Signature _____

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