| Brookhaven SDA School4658 Reedy Branch RoadWinterville, NC 28590252-756-5777Emergency Consent to Treatment School Year 20     – 20      Grade        |
| --- |
| Information |
| Student’s Full Name:       |
| Home Phone Number:       |
|  |
| Mother’s Name:       |
| Work Phone Number:       |
| Cell Phone Number:       |
|  |
| Father’s Name:       |
| Work Phone Number:       |
| Cell Phone Number:       |
|  |
| (Please supply the following guardian information if applicable.) |
| Legal Guardian Name:       |
| Work Phone Number:       |
| Cell Phone Number:       |
|  |
| Physician’s Name:       |
| Office Number:       |
| Choice of Hospital:       |
|  |
| We, the undersigned parents/legal guardian, of the student do herby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital services that may be rendered. It is understood that reasonable effort will be made to contact the parents/guardian and the physician listed above before any other physician is called by the school. It is understood that this consent is given in advance of any specific diagnosis or treatment which might be required.  |
| Current Family Health Insurance Company and Policy Number     Policy Number:       Group #     Parent(s) SignaturesDate Signed: \_\_\_\_\_\_\_\_\_\_\_\_  |