Southwestern Union Conference
CONSENT TO TREATMENT

Only designated staff, such as the school nurse or physician, will have access to the completed form. This form will be stored in a locked file.

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 _____ Social Security Number _____
Mo. Day Year

Address _____

Parent/Guardian's Name _____

Father/Guardian _____ _____ _____
Business Telephone Home Telephone Social Security Number

Mother/Guardian _____ _____ _____
Business Telephone Home Telephone Social Security Number

Please describe allergies to substances and medication. _____

If on regular medication, please specify _____ Date of last tetanus shot _____

Please give the name of your local family physician(s) to be called in case your son or daughter becomes ill or has an accident at school and you cannot be reached.

1. Family Physician _____ Office Telephone _____

   Address _____

2. Family Physician _____ Office Telephone _____

   Address _____

Hospital preference _____ Telephone _____

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 _____

   Address _____

2. Name _____ Telephone _____

   Address _____

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.

Signature of Parent or Guardian: _____ Date: _____

PHYSICIAN'S EXAMINATION*

Height _____ Weight _____ Blood Pressure _____

	Normal	Abnormal	Not Examined	Explain Abnormalities
Skin				
Eyes, vision, glasses				
Ears, hearing				
Nose and throat				
Mouth, teeth, speech				
Glands				
Chest, lungs				
Cardiovascular, heart				
Abdomen, enlargement				
tenderness				
hernia				
Spine, back				
Scoliosis				
Posture				
Extremities				
Genitourinary				
Nervous System, reflexes				

Nutritional Status and general appearance of the child _____

_____

Recommendations for additional medical or dental care _____

This student may participate in a normal physical education program which includes such activities as running, jumping, tumbling.

❑ Yes ❑ No

If student must be restricted from participating in activities such as are listed above, please indicate physical activities that may be permitted.

_____

Date _____ Physician's Signature _____

Address _____

*To be completed by the family physician and kept on file at the school for all children, a) entering school for the first time, b) at age 11, c) at least once in grades nine through twelve, and d) at other grades, when required by the Conference Board of Education.

STUDENT MEDICAL RECORD

Only designated staff, such as the school nurse or physician, will have access to the completed form. This form will be stored in a locked file.

Name _____ Birth Date _____

Address _____

_____ Social Security Number _____

Name of Father _____ Name of Mother _____

History (Past illnesses and allergies. Please check those he/she has had.)

- ❑ Cancer
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Diphtheria
- ❑ Epilepsy
- ❑ Heart Disease
- ❑ Measles
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Tuberculosis
- ❑ Whooping Cough
- ❑ Ear Infections
- ❑ Other

Allergies:

- ❑ Asthma
- ❑ Hay Fever
- ❑ Insect Bites
- ❑ Penicillin
- ❑ Other Drugs

Explain briefly factors as surgeries, serious accidents or injuries, congenital defects, which may affect the child's school experience

_____

Indicate physical problem by check: Hearing ( ) Heart ( ) Sight ( ) Speech ( )

Other _____
SPECIFY

IMMUNIZATIONS – An official record of immunizations must accompany this medical record for all students entering school for the first time in the United States regardless of grade level. Records considered official are:

State Immunization Record
Health Provider Record – must have signature, stamp, or initials next to each date.
Physician's Record
County Health Department Record
Official Immunization Record from another state
School Immunization Record

LABORATORY RECORD

	Type*	Dates Given	Given by	Date Read	Read by		Impression
TB SKIN TESTS	❑ PPD Mantoux ❑ Other _____	/ / / /		/ / / /			❑ Pos ❑ Neg
	❑ PPD Mantoux ❑ Other _____	/ / / /		/ /' / /			❑ Pos ❑ Neg
	❑ PPD Mantoux ❑ Other _____	/ / / /		/ / / /			❑ Pos ❑ Neg

*If required by school entry, must be Mantoux unless exception granted by local health department

CHEST X-RAY Film date: _____/_____/_____ Impressing: ❑ Normal ❑ Abnormal

Person is free of communicable tuberculosis ❑ Yes ❑ No

Signature/Agency _____