Grants Pass
Seventh-day Adventist School

CONSENT TO TREATMENT

PARENTS/GUARDIANS: Complete a form for each student. Please print clearly.

CONTINUOUS CONSENT TO TREATMENT

We, the undersigned parent or guardian of (student's name) _____ a minor, do hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered to said minor under the general or special instructions of (student's physician) _____, M.D., at (physician's phone #)_____ or any physician the school may call, whether such diagnosis or treatment is rendered at the office of said physician or at a licensed hospital. It is understood that reasonable effort will be made to contact the doctor listed above before any other physician is called.

It is further understood that this consent is given in advance of any specific diagnosis or treatment which might be required and is given to authorize Grants Pass Adventist School or the physician to exercise their best judgment as to the requirements of such diagnosis or treatment. This consent shall remain in continuous effect until revoked in writing and delivered to the physician named above or to the school entrusted with the custody of said minor.

We would like to have our student go on all field trips. We recognize that the teacher and those assisting are to use their best judgment in caring for the children while on these trips. We absolve the school and the directing personnel from any legal liability.

The above named student ☐ is ☐ is not covered by health insurance.

Current Health Insurance Company: _____

Member #: _____ Group #: _____

Which hospital does your insurance cover?_____

Parent/Guardian's Printed Name: _____ Date:_____

Parent/Guardian's Signature: _____

CONTACT INFORMATION

Father/Guardian	Mother/Guardian
Name:_____	Name: _____
Cell Phone #:_____	Cell Phone #: _____
Daytime Phone #:_____	Daytime Phone #: _____

Grants Pass Adventist School
2250 NW Heidi Lane
Grants Pass OR 97526

www.gpsdaschool.org
office@gpsdaschool.org
Phone: 541 479-2293

MEDICAL INFORMATION FOR STUDENT

Medical Conditions and Medications Taken (such as asthma, heart, etc.):

_____

_____

_____

_____

_____

_____

Oral Medication Policy:

Grants Pass Adventist School is authorized to administer oral medication to students during school hours ONLY after a parent/guardian and/or physician has signed a permission form. It is our policy that such medication will only be administered when the failure to receive medication may result in the student being unable to attend school and/or be well enough to participate in learning activities. Please include original instructions with all medications still in their original containers. We define medication to include all drugs, whether prescription or over-the-counter.

I give permission to Grants Pass Adventist School to administer any necessary medication according to their policy. I agree to include original instructions with all medications still in their original containers.

Signed: _____ Date: _____

ALERGY INFORMATION FOR STUDENT

Medication Allergies: ☐ Yes ☐ No

Explain: _____

Bee Sting Allergies: ☐ Yes ☐ No

Severity of Allergy:_____

Antidote Name:_____

Food Allergies: ☐ Yes ☐ No

Explain: _____

Environmental Allergies: ☐ Yes ☐ No

Explain (grass, cats, bandage materials, etc.)_____

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