Brookhaven SDA School
4658 Reedy Branch Road
Winterville, NC 28590
252-756-5777

EMERGENCY 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) Signatures

Date Signed: _____