

Consent for Hospital / Physician's Care Form

2009-2010 School Year

This form must be completed and returned to Hillside prior to attending this school year.
This form must be updated for each student every year.

CHILD'S NAME _____ DATE OF BIRTH _____ (00/00/0000) Boy Girl

_____ WA _____
street address city state zip

MOTHER'S NAME _____
MOTHER'S PHONE NUMBERS:

home: () work: () cell ()

FATHER'S NAME: _____
FATHER'S PHONE NUMBERS::

home: () work: () cell ()

In the event that my child _____, is in need of medical/dental attention while
(child's name)
at Hillside Student Community, and every reasonable attempt to reach me/us is unsuccessful, I/we give
permission for _____ to receive medical/dental evaluation /treatment as needed.
(child's name)

_____ Parent's or guardian's signature _____ Parent's or guardian's name printed
date

BRIEF MEDICAL HISTORY (may send additional pages)

1. CIRCLE AND EXPLAIN ANY OF THE FOLLOWING WHICH APPLY TO YOUR CHILD:

seizures diabetes heart problems asthma immune system disorders other

explain:

2. MEDICATION OR FOOD ALLERGIES

3. ROUTINE MEDICATIONS

4. YEAR OF LAST TETANUS SHOT: _____ / _____ / _____