2019-2020

SAN GABRIEL ACADEMY
MEDICAL CONSENT TO TREATMENT

8827 E. Broadway. San Gabriel, CA 91776 (626) 292-1156 www.sangabrielacademy.org

Incomplete applications will not be accepted.

STUDENT INFORMATION

Last Name | First | Middle | Name Used

Address (Street and PO Box) | City | State | Zip

Birthdate (MM/DD/YYYY) | Age

PARENT / GUARDIAN INFORMATION

Last Name | First | Relationship

Home Telephone | Work Telephone | Cellular

STUDENT'S HEALTH INFORMATION

List Any Medical Conditions (e.g. Asthma, Diabetes)

List Any Allergies (e.g. Medication, Food)

Prescription Medication(s)

Date of Last Tetanus Shot

STUDENT'S MEDICAL CARE INFORMATION

Physician Full Name | Telephone

Address (Street and PO Box) | City | State | Zip

Hospital Preference

Medical Insurance? ☐ Yes ☐ No | Policy Number

Insurance Company | Phone Number

STUDENT'S CONTACT OTHER THAN A PARENT/GUARDIAN

Full Name | Relationship

Home Telephone | Work Telephone | Cellular

If emergency medical or dental care and treatment is required and neither parent or guardian can be reached, I give the sponsor/agents from San Gabriel Academy School permission to act in our behalf to obtain required diagnosis, treatment, and/or hospitalization that is recommended by the physician/dentist. Consent is hereby given to physicians and dentists to perform required emergency diagnoses and treatment, including administering medications and surgical procedures deemed necessary.

_____ Legal Guardian Signature

_____ / ____ / ____ Date