1 Per Student Consent to Treatment
Riverview Christian Academy

Only designated staff 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 Full Name: _____

_____ _____
Date of Birth (month/day/year) Social Security Number (United States)

Parent/Guardian Information:
Father/Guardian: _____

_____ _____ _____
Business Phone Mobile Phone Social Security Number

Mother/Guardian: _____

_____ _____ _____
Business Phone Mobile Phone Social Security Number

Please describe allergies to substances and medications: _____

If on regular medication, please specify: _____ _____
Date of Last Tetanus Shot

Please give the name of your local family physician to be called in case your child becomes ill or has an accident at school and you cannot be reached:

_____ _____
Family Physician Name Office Phone

Physician's Office Address: _____

Hospital Preference: _____ _____
Hospital Phone

Please give the name of a relative or friend who has consented to assume the responsibility of your child in case of illness or accident until you can be reached. In case of any changes in the named person, notify the school in writing.
Name:_____ _____
Phone

Address: _____

The above named student is: _____ or is not: _____ covered by health insurance.

_____ _____
Present Health Insurance Company Policy Number

If emergency service involving medical action or treatment is required and neither the parent not 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 service.

_____ _____
Signature of Parent or Guardian Date