NORTH DALLAS ADVENTIST ACADEMY

Emergency Information			
Student's First & Last Name:		DOB (mm/dd/yyyy):	
		Social Security #:	
Student's Address (U.S. only) :	City:	State:	Zip Code:
Mother's First & Last Name:	Home Phone #:	Cell Phone #:	Work Phone #:
Father's First & Last Name:	Home Phone #:	Cell Phone #:	Work Phone #:
Guardian's First & Last Name:	Home Phone #:	Cell Phone #:	Work Phone #:
Emergency Contact First & Last Name: (must be someone other than parent or guardian)		Phone #:	Relationship to Student:
First & Last Name of Student's Doctor:		Doctor's Office Phone #:	

Continuing Consent to Treat 2010-2011 School Year

We, the undersigned parents/guardians of ______________________________ a minor, do hereby consent to any x-ray examination, anesthesia, a medical or surgical diagnosis or treatment that any hospital service may render to said minor under the general or special instructions of North Dallas Adventist Academy personnel, whether said diagnosis or treatment is rendered at the office of said physician/dentist or at a licensed hospital.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given to encourage the school personnel and said physician/dentist to exercise his/her best judgment as to requirements of such diagnosis or treatment.

It is also understood that every possible attempt will be made to contact the parents first. Only in case of extreme emergency and failure to be able to contact the parents/guardians will this apply.

Is there an illness, ailment, or condition that we should be made aware of? (i.e. allergies, asthma, diabetes, etc.)

☐ No ☐ Yes - Please explain: ______________________________
(List any medications the student is on.)______________________________

______________________________ ______________________________
Parent/Guardian Signature Date