Consent to Treat 2018-2019

Emergency Information			
Student's First & Last Name:		DOB (mm/dd/yy)	Grade:
Student's Address (U.S only)	City:	State:	Zip
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 #:	

We, the undersigned parents/guardian 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 judgement 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 is 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

2800 Custer Parkway | Richardson, TX, 75080 | Phone 972.234.6322 | Fax 972.234.6322
Office@ndaacademy.org | NdaAcademy.org

Consentimiento para Tratar 2018-2019

Emergency Information			
Student's First & Last Name:		DOB (mm/dd/yy)	Grade:
Student's Address (U.S only)	City:	State:	Zip
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 #:	

Nosotros, los padres/guadianes de _____un(a) menor, Damos el consentimiento para que se haga examinacion de x-ray, anesthesia o un diagnostic de cirujia or tratamiento que el hospital de servicio hecho al menor en cuestion bajo las direcciones especiales o generals de el personal de North Dallas Adventist Academy, ya sea que el diagnostic o tratamiento sea dado en la oficina de el doctor/dentista referido aqui o en un hospital registrado.

Entiendo que este consentimiento es dado en avance de un diagnostico especifico o tratamiento requerido, pero es dado para formentar o alentar al peronal de la escuela/insitiucion y de el doctor regerido aqui para ejercitar su major juicio al necesitar diagnostico o tratamiento.

Es tambien entendido de que todo posible intento sera hecho para ponerse en contacto con los padres primero. Solo en caso de una emergencia exrema o de no haber podido conectarse con los padres o guardians esto se aplicara.
Hay alguna endermedad o condicion de la cual debieramos saber? (i.e. alergias, asthma, diabetis etc.)

☐ NO ☐ Si – Por favor explique: _____
(Haga lista de las medicaciones que el estudiante toma _____

_____ _____
Firma del Padre/Guardian Fecha