CONSENT TO TREAT

STUDENT INFORMATION

Student's Legal Name | Age | Date of Birth (/ /) | Grade

In the event your child should suddenly become ill or injured while at school, prompt medical attention may be required. A delay of hours while locating parents could be serious. Therefore, Minnetonka Christian Academy is asking you to authorize medical, dental, and health treatment should the need occur.

I, the undersigned parent or legal guardian of the above-named minor, do consent to any x-ray examination, dental treatment, anesthetic, medical or surgical diagnosis or treatment, hospital service or mental or behavior health treatment of services that may be required to aid a minor under the general or specific insurance of physician, whether such diagnosis or treatment is rendered at Minnetonka Christian Academy, the office of a physician, or at a licensed hospital. I consent to the administration of over-the-counter medications and those ordered by a physician.

It is further understood that this consent is given in advance of any specific diagnosis or treatment that might be required and is given to authorize Minnetonka Christian Academy or the physician to exercise their best judgment as to the requirements of such diagnosis or treatment. A copy of this authorization shall be considered as effective and valid as the original. This consent shall remain in continuous effect as long as my child is enrolled at Minnetonka Christian Academy or under the supervision of Minnetonka Christian Academy or until revoked in writing delivered to the school administration entrusted with custody of said minor.

MEDICAL INFORMATION:

FOOD & DRUG ALLERGIES:

Physician's Name | Name of Practice & location | Telephone ( )

Parent/Guardian Signature | Date / /

Please include a copy of current insurance card

STUDENT MEDICAL HISTORY

STUDENT INFORMATION

DATE OF THIS FORM: _____

Student's Legal Name | Age | Date of Birth (__/__/__) | Grade

Parent/Guardian Name | Home Phone ( )

HEALTH HISTORY *(to be filled out by parent)*

DISEASES *(Please state year of problem)*

CHICKEN POX _____
MUMPS _____
HEPATITIS _____
SCARLET FEVER _____
MEASLES(HARD) _____
WHOOPING COUGH _____
MEASLES(RUBELLA) _____
MENINGITIS _____
MONONUCLEOSIS _____
OTHERS _____

CHRONIC & RECURRING ILLNESSES *(state year and clarify where necessary)*

ANIMAL ALLERGY _____
DIABETES _____
DRUG ALLERGY _____
EAR INFECTION _____
EYE INFECTION _____
HAY FEVER _____
HEART DISEASE _____
INSECT STING ALLERGY _____
HEMOPHILIA _____
ASTHMA _____
BONE/MUSCULAR DISEASE _____
FOOD ALLERGIES _____
COLDS _____
PNEUMONIA _____
OTHER ALLERGY _____
PHYMATIC FEVER _____
SEIZURES _____
SKIN INFECTIONS _____
STREP INFECTION _____
TUBERCULOSIS _____
STOMACH ULCERS _____
SKIN ULCERS _____
OTHERS _____

OPERATIONS/INJURIES/HOSPITALIZATION: SPECIFY YEAR & TYPE

SIGNIFICANT FAMILY ILLNESSES PROBLEMS

CURRENT MEDICATIONS

DOCTOR HEALTH EXAMINATION

PHYSICAL EXAMINATION FOR _____ DATE OF EXAMINATION: _____

			RIGHT:	LEFT:	RIGHT:	LEFT:
Height	Weight	Pulse	Vision		Hearing	

Physical	Normal	Abnormal	Follow Up/Comments
Skin			
Abdomen			
Eyes			
Hernia			
Ears			
Mouth			
Heart			
Lungs			
Glands			
Extremities			
Nose and Throat			
Genitourinary			
Gastrointestinal			
Neurological			
Muscular Skeletal			
Nutritional Status			
Mental Status			

SPECIFIC MEDICAL RECOMMENDATIONS TO SCHOOL FOR ACADEMIC & ACTIVITY PROGRAMS:

I certify that I have examined this student. On the basis of this examination, I have found no reason that would make it medically inadvisable for this student to participate in supervised physical education activities.

Physician's Printed Name | Physician's Signature | Date ___/___/___

Address | City | State | Zip Code

( ) Phone