

MEDICAL TREATMENT FORM

E. A. Sutherland Education Association
P.O. Box 495, Collegedale, TN 37315
Phone (423) 396-4545 – Fax (423) 396-4441

Please Note: Photocopies will be made. Please PRINT using black or dark blue ink. (NO pencil please!)

Student Name _____ Social Security # ____ - ____ - _____
Address _____
Street _____ City _____ State _____ Zip _____
Home Phone (____) ____ - _____ Date of Birth ____/____/____
Parent/Guardian Legal Name _____ Social Security # ____ - ____ - ____
Employer _____ Work Phone # (____) ____ - ____
Insurance Company _____ Policy Number _____

INFORMATION WHICH MAY BE IMPORTANT IN AN EMERGENCY

1. Medications which the student takes regularly: _____
2. Allergic reactions to medications, foods, or contact with natural or artificial matter: _____
3. Medical conditions such as diabetes, convulsions, asthma, etc., about which the attending physician should know in advance of diagnosis or treatment: _____

CONTINUING CONSENT TO MEDICAL TREATMENT AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

In the event of illness or accident, we, the undersigned parents or legal guardians of _____ (student's name), a minor, do hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital service which may be rendered to said minor under the general or special instructions any physician the EASEA representative may call, whether such diagnosis or treatment is rendered at the office of said physician or at a licensed hospital. It is understood that reasonable effort will be made to contact the parent or guardian.

It is further understood that this consent is given in advance of any specific diagnosis or treatment which might be required and is given to authorize the physician to exercise their best judgment as to requirements of the diagnosis or treatment. EASEA officials are authorized to sign any necessary paperwork for us/me.

This consent shall remain in effect for the duration of this student's enrollment in the EASEA Mission Trip Program for the current school year unless revoked in writing and delivered to the EASEA office.

We hereby authorize any hospital, physician, or other medical personnel who has attended or examined the minor to furnish our insurance company, _____ (name of company), or its representative, any and all information with respect to any illness, medical history, consultation, prescriptions, or treatment, and copies of all hospital or medical records.

A photocopy of this authorization shall be considered as effective and valid as the original.

REQUIRED SIGNATURES

Signature of Father or Legal Guardian: _____ Date _____
Signature of Mother or Legal Guardian: _____ Date _____

Signed, sealed, and acknowledged before me, on this the ____ day of _____, 20 ____.

Notary Public County/State My commission expires: _____

Name of Family Physician: _____ Phone _____
Name of Emergency Contact in case the above cannot be reached: _____
Phone Number of Emergency Contact: _____ Relationship to student: _____