Thunderbird
Adventist Academy
CONSENT TO TREATMENT

Only designated staff, such as the school nurse or Dean, will have access to the completed form.

Student Full Legal Name _____ Date of Birth _____
Mo. Day Yr.

Address _____ _____ _____
Number & Street State Zipcode

Mother/Guardian Name _____ Date of Birth_____

Business Phone _____ Home Phone _____

Father/Guardian Name _____ Date of Birth_____

Business Phone _____ Home Phone _____

Please describe allergies to substances and medication _____

_____

If on regular medication, please specify _____

Date of last tetanus shot _____

We, the undersigned parent or guardian of _____, a student at Thunderbird Adventist Academy, do hereby consent to any necessary examination, anesthetic, blood transfusion, medical diagnosis, x-ray examination, mental health care, etc., and/or hospital care to be rendered to our child under the instructions of the physician designated by the staff of Thunderbird Adventist Academy. These services may be rendered at the physician's office or a licensed hospital. It is understood that reasonable effort will be made to contact the parent or guardian in the case of an emergency. Still, that consent is hereby given in advance of any specific diagnosis or treatment that might be required and is given to authorize the staff of Thunderbird Adventist Academy, the Physician, or the Hospital staff to exercise their best judgment in the medical care.

This consent shall remain in continuous effect for the school year of 2024-2025 or until revoked in writing and delivered to Thunderbird Adventist Academy.

Please check the appropriate box below:

My son/daughter is covered by medical insurance.
NOTE: A copy of your medical insurance card (both front and back sides) is required. Please submit a copy of your card with this consent form.

My son/daughter is not covered by medical insurance.

ALL CHARGES FOR ACCIDENTS ARE TO BE SENT TO THE PARENTS. The student accident insurance may cover any costs of school-related accidents after the parent's primary insurance pays its portion. Any non-accident medical treatment is the sole responsibility of the parent/guardian.

Notary Seal

Signature of Parent or Guardian _____ Date _____