WINTER HAVEN ADVENTIST ACADEMY

AN ACCREDITED SEVENTH-DAY ADVENTIST CHRISTIAN SCHOOL

PO Box 7169 ~ Winter Haven, FL 33880 ~ (863) 299-7984

https://winterhaven22.adventistschoolconnect.org/

Adventist Education
A JOURNEY TO EXCELLENCE

MEDICAL CONSENT FORM

MUST BE NOTARIZED

Student's Full Name _____

Birth Date _____ Sex _____

Mailing Address _____

Home Address if different _____

Student's Social Security Number (SS#) _____

Mother's Name _____ SS#_____

Phone: Home _____ Work _____ Cell _____

Home Address if different _____

Father's Name _____ SS#_____

Phone: Home _____ Work _____ Cell _____

Home Address if different _____

Other Legal Guardian's Name _____

Phone: Home _____ Work _____ Cell _____

Student's Physician _____ Phone _____

Office Address _____

Student's Medical History (i.e.; breathing, conditions, diabetes, surgery) _____

_____

Student's Current Medications _____

Student's Allergies (food or medicine) _____

Other Medical Concerns (if any) _____

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MEDICAL CONSENT FORM SCHOOL YEAR_____

MUST BE NOTARIZED

I, _____, give my consent for first aid and emergency
(Parent or Guardian Name)

medical treatment to be administered to my child, _____,
(Student's Name)

named and conditions described on page one (1) of this document.

When my child is on school trips off campus, this consent will also include administering over-the-counter medications (i.e.; pain medications, antihistamines, and decongestant/ cough medicine, etc) when deemed necessary.

DO NOT GIVE the following medications to my child: (List all medications that your child should not have) _____

_____

Signature of Parent or Guardian _____

Printed name of Parent or Guardian _____

Date _____

Notary Signature and Seal _____