



HAWAIIAN MISSION ACADEMY K-8

1415 Makiki Street Honolulu, HI 96814 (808) 949-2033 www.hmak12.org

CONSENT TO TREATMENT

This form will be kept confidential.

Student's Name _____

Age _____ Date of Birth _____ Social Security Number _____
mo. day yr.

Address _____

Father's/Guardian's Name: _____

Phone Numbers: _____
Business Telephone Home Telephone Social Security Number

Mother's/Guardian's Name: _____

Phone Numbers: _____
Business Telephone Home Telephone Social Security Number

Please describe allergies to substances and medication. _____

If on regular medication, please specify _____ Date of last tetanus shot _____

Please give the name of your local family physician to be called in case your son or daughter becomes ill or has an accident at school and you cannot be reached.

1. Family Physician _____ Office Telephone _____

Address _____

Hospital preference _____ Telephone _____

Please give the names of three relatives or friends (other than parents) who have consented to assume the responsibility of your child in case of illness or accident until you can be reached or who has the authority to take your child from the facility. In case of any changes in the named persons, notify the school in writing.

1. Name _____ Telephone _____

Address _____ Alt. Phone _____

2. Name _____ Telephone _____

Address _____ Alt. Phone _____

3. Name _____ Telephone _____

Address _____ Alt. Phone _____

If emergency service involving medical action or treatment is required and neither the parent nor the family physician can be reached for consent, the parents hereby consent to the rendering of such emergency medical service for the above named student as shall be necessary in the medical opinion of the doctor rendering the service. This authorization is given pursuant to the local state Civil Code.

Signature of Parent or Guardian: _____ Date: _____