

Puget Sound Christian School & Daycare

1740 South 84th Street Tacoma, Washington 98444 253.537.6870 www.pschristianschool.com

2019-2020 Student Medical Consent Form

PLEASE PRINT and FILL IN ALL INFORMATION. If information is not pertinent, please write in N/A.

Child's Name _____ Birthday _____ Boy Girl

Address _____ City _____ State _____ Zip _____

Mother/Guardian Name _____ SS # _____ - _____ - _____

Home Address _____ Cell # _____

Father/Guardian Name _____ SS # _____ - _____ - _____

Home Address _____ Cell # _____

Child's Primary Physician _____ Phone _____

Address _____ City _____ State _____ Zip _____

Child's Dentist _____ Phone _____

Address _____ City _____ State _____ Zip _____

Primary Medical Insurance _____

Group # _____ Subscriber _____

Secondary/Supplemental Insurance _____

Group # _____ Subscriber _____

HEALTH HISTORY/INFORMATION:

Please check all that apply:

- | | |
|---|---|
| <input type="checkbox"/> Medications Being Taken _____
Time of Dose? _____ | <input type="checkbox"/> Nosebleeds: <input type="checkbox"/> Occasionally <input type="checkbox"/> Chronic |
| <input type="checkbox"/> RX Allergy _____
Results _____ | <input type="checkbox"/> Ear Infections? <input type="checkbox"/> Occasionally <input type="checkbox"/> Chronic |
| <input type="checkbox"/> Diabetic, Explain _____ | <input type="checkbox"/> Hearing loss: <input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Both |
| <input type="checkbox"/> Blood Disease, Explain _____ | <input type="checkbox"/> Wears Eyeglasses: <input type="checkbox"/> All the time <input type="checkbox"/> Reading only |
| <input type="checkbox"/> Epilepsy, Explain _____ | <input type="checkbox"/> Chronic Diseases, Explain _____ |
| <input type="checkbox"/> Rheumatic Fever, Explain _____ | <input type="checkbox"/> Heart Disease, Explain _____ |
| <input type="checkbox"/> Seizures? Frequency? _____ | <input type="checkbox"/> Hypertension, _____ |
| <input type="checkbox"/> ADD <input type="checkbox"/> ADHD | <input type="checkbox"/> Kidney Disease, Explain _____ |
| <input type="checkbox"/> Allergies/Hayfever? _____ | <input type="checkbox"/> Convulsions? Explain _____ |
| <input type="checkbox"/> Chicken Pox, Date: _____ <input type="checkbox"/> German Measles, Date _____ | <input type="checkbox"/> Food Allergies? _____
Results _____ |
| <input type="checkbox"/> Mononucleosis, Date _____ | <input type="checkbox"/> Measles, Date _____ <input type="checkbox"/> Mumps, Date _____ |

Date of last Tetanus Shot: _____ Date of Last Physical Exam: _____

(Must be within one year of start date)

Operations or Serious Injuries? Yes No Explain _____

Medical and Surgical Consent

If my child requires medical or dental treatment, I, the undersigned, hereby consent to all treatments by the attending physician or dentist and to the administration and performance of all examinations, administering of medicine, treatments, anesthetics, operations, X-rays, blood tests, transfusions, suturing or other procedures, which may be deemed necessary for my child, listed above during the stay at this hospital.

Financial Agreement

I, the undersigned, hereby agree to accept responsibility for any financial indebtedness incurred during the hospitalization. I agree to pay for all necessary services at the current rate and in case of collection, pay a reasonable attorney fee and collection expense.

I have read the above medical/surgical consent and financial policy. I understand and agree to their content. All information printed is correct.

Father/Legal Guardian Signature _____ Date _____

Mother/Legal Guardian Signature _____ Date _____