Puget Sound Christian School & Daycare

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

2024-2025 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:

☐ Medications Being Taken _____
Time of Dose? _____
☐ RX Allergy _____
Results _____
☐ Diabetic, Explain _____
☐ Blood Disease, Explain _____
☐ Epilepsy, Explain _____
☐ Rheumatic Fever, Explain _____
☐ Seizures? Frequency? _____
☐ ADD ☐ ADHD
☐ Allergies/Hayfever? _____
☐ Chicken Pox, Date: _____ ☐ German Measles, Date _____
☐ Mononucleosis, Date _____

☐ Nosebleeds: ☐ Occasionally ☐ Chronic
☐ Ear Infections? ☐ Occasionally ☐ Chronic
☐ Hearing loss: ☐ Right Ear ☐ Left Ear ☐ Both
☐ Wears Eyeglasses: ☐ All the time ☐ Reading only
☐ Chronic Diseases, Explain _____
☐ Heart Disease, Explain _____
☐ Hypertension, _____
☐ Kidney Disease, Explain _____
☐ Convulsions? Explain _____
☐ Food Allergies? _____
Results _____
☐ Measles, Date _____ ☐ 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 _____