

# Consent to Treatment

Walla Walla Valley Academy  
300 SW Academy Way, College Place, WA 99324  
(509)-525-1050

Student's Name: \_\_\_\_\_ Birthday: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_

Father's name: \_\_\_\_\_ Mother's name: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Phone-Home: \_\_\_\_\_ Phone-Home: \_\_\_\_\_

Work: \_\_\_\_\_ Work : \_\_\_\_\_

Family Medical Insurance (Primary): \_\_\_\_\_

Policy Number: \_\_\_\_\_

Contact in Emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

(other then parents or guardians)

Work \_\_\_\_\_

This Yearly **Consent to Treatment** shall remain in effect for the current school year unless revoked in writing by the parents or guardians.

In our absence and/or unavailability, the hospital, its physicians and other health care personnel are authorized to render emergency or medical treatment considered necessary by the hospital's emergency physician for the about student.

**Our child has permission to use WWVA's climbing wall.**            **Yes**            **No**

**Our child had permission to go on general class field trips.**            **Yes**            **No**

If possible, please try to reach the following physician, otherwise the physician on call at the hospital should be contacted.

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Surgeon: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature of Parent: \_\_\_\_\_ Date: \_\_\_\_\_

## Medical History

Prior Illnesses: \_\_\_\_\_

Allergies: \_\_\_\_\_

Date of last tetanus immunization: \_\_\_\_\_