Hartland
DAY ACADEMY

TREATMENT IN CASE OF ILLNESS OR INJURY

Student Blood Type:_____

Name of student_____ Home phone number_____

In case of illness or injury, school personnel will make every effort to contact the parents or guardians with whom the student is living. If you cannot be reached at home, the following number supplied by you will help us either reach you or your doctor.

_____

NAME CELL PHONE NUMBER / WORK PHONE NUMBER

_____

DESIGNATED PERSON AND PHONE NUMBER TO CALL IF PARENTS CANNOT BE REACHED

_____

FAMILY DOCTOR'S NAME AND OFFICE PHONE NUMBER

CONTINUING CONSENT TO TREATMENT AND HEALTH INSURANCE INFORMATION

We, the undersigned parents or guardians of _____, a minor< do herby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered to said minor under the general or special instructions of _____, M.D. or any physical or at a licensed hospital. It is understood that reasonable effort will be made to contact the doctor listed above before.

It is further understood that this consent is given in advance of any specific diagnosis or treatment, which might be required and is given to authorize **HARTLAND DAY ACADEMY** or the physician to exercise their best judgment as to the requirements of such diagnosis or treatment.

This consent shall remain in continuous effect until revoked in writing and delivered to the physician named above or to the school or organization entrusted with the custody of said minor.

The above-named student:

- ☐ Is covered by health insurance
- ☐ Is not covered by health insurance

Present health insurance company_____

Policy number_____

_____ _____

FATHER'S SIGNATURE DATE

_____ _____

MOTHER'S SIGNATURE DATE

_____ _____

LEGAL GUARDIAN WITNESS