HILLSIDE STUDENT COMMUNITY SCHOOL

Consent for Hospital or Physician's Care

- This form must be completed and returned to Hillside prior to attending this school year.
- This form must be updated for each student every year.

Please fill out, print and mail this form to:

Hillside Student Community School
Attn: Joel Slagle
5027 159th Pl. SE
Bellevue, WA 98006-3636

Child's Name: _____ Date of Birth: _____ BOY / GIRL (circle one)

Street Adress: _____

City: _____ State: _____ Zip: _____

Mother's Name: _____ Father's Name: _____

Home Phone: _____ Home Phone: _____

Work Phone: _____ Work Phone: _____

Cell Phone: _____ Cell Phone: _____

In the event that my child _____, is in need of medical/dental attention while at Hillside, and every reasonable attempt to reach me/us is unsuccessful, I/we give permission for to receive medical/dental evaluation /treatment as needed.

Parent's or Guardian's Name Printed: _____

Parent's or Guardian's Signature: _____ Date _____

Brief Medical History (may send additional pages)

Circle and explain any of the following which apply to your child:

seizures | diabetes | heart | problems | asthma | immune system disorders | other

Please explain: _____

Medication or food allergies: _____

_____

_____

Routine medications: _____

_____

Year of last tetanus shot: _____