Hawaiian Mission Academy Windward Campus
CONSENT TO TREATMENT

Only designated staff, such as the school nurse or physician, will have access to the completed form. This form will be stored in a locked file.

This form must be filled out at the beginning of each school year to cover the activities for the school year. A copy of each student's form must be taken on off-campus activities.

Student's Name: _____ Age:_____

Date of Birth:_____Social Security Number: _____

Address: _____

Parent/Guardian's Name: _____

Father/Guardian _____ _____ _____
Business Phone Cell Phone Social Security Number

Mother/Guardian _____ _____ _____
Business Phone Cell Phone Social Security Number

Please describe allergies to substances and medication: _____

If on regular medication, please specify: _____

Date of last Tetanus shot: _____

Please give the name of your local family physician(s) to be called in case your son or daughter becomes ill or has an accident at school and you cannot be reached.

1. Family Physician:_____ Office telephone: _____

Address: _____

Hospital preference:_____ Telephone: _____

Please give the names of two relatives or friends who have consented to assume the responsibility of your son or daughter in case of illness or accident until you can be reached. In case of any changes in the named persons, notify the school in writing.

1. Name:_____ Telephone: _____

Address: _____

2. Name:_____ Telephone: _____

Address: _____

If emergency service involving medical action or treatment is required and neither the parent nor the family physician can be reached for consent, the parents hereby consent to the rendering of such emergency medical service for the above named student as shall be necessary in the medical opinion of the doctor rendering the service. This authorization is given pursuant to the local state of the civil code.

Signature of Parent of Guardian:_____ Date: _____

HAWAIIAN MISSION ACADEMY WINDWARD CAMPUS

OFFICE DIRECTORY CARD

Year: 2022-2023

STUDENT LAST NAME:

First Name:	Middle Name:	Grade:	DOB:	Sex:
First Name:	Middle Name:	Grade:	DOB:	Sex:
First Name:	Middle Name:	Grade:	DOB:	Sex:
Address:		City:	Zip:	

FATHER INFORMATION

Last Name:	First Name:	Home/Cell Phone:
Baptized SDA Church:	Occupation:	Business Phone:

MOTHER INFORMATION

Last Name:	First Name:	Home/Cell Phone:
Baptized SDA Church:	Occupation:	Business Phone:

EMERGENCY INFORMATION

Physician:	Phone:	Hospital:	Phone:
In case of emergency contact:		Phone:	

Hawaiian Mission Academy Windward Campus
Before/After School Care Registration

_____ Yes, I need extended care for my child/children.

_____ No, I don't need extended care for my child/children. I will pick up my child/children when school gets out. And I understand that Hawaiian Mission Academy Windward Campus will not be held responsible for my child/children if I am not able to pick up my child on time.

_____ Sometimes, I may need extended care for my child/children. I will call or notify the secretary as needed.

Name of child/children:_____

_____ _____
Parent/Guardian Signature Date

Hawaiian Mission Academy Windward Campus
Extended Care Pick Up Authorization

Student's Name:_____ Grade:_____

Parent's Name:_____ Phone:_____

Address:_____
Number & Street Name City Zip

The following persons are authorized to pick up my child from after care:

Name:_____ Phone:_____

Address:_____
Number & Street Name City Zip

Name:_____ Phone:_____

Address:_____
Number & Street Name City Zip

Name:_____ Phone:_____

Address:_____
Number & Street Name City Zip

_____ _____
Parent's Signature Date