# CONSENT FOR TREATMENT

## 20___ - 20___ SCHOOL YEAR

I/We the undersigned parents or legal guardians of ______________________________, a minor, do hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital services that may be rendered to said minor under the general or special supervision of any physician and surgeon, licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at the licensed hospital. It is understood that reasonable effort will be made to contact the doctor listed before any other physician is called by the school or other organization.

It is further understood that this consent is given in advance of any specific diagnosis, treatment or hospital care which might be required, but is given to provide authority to the ____________________________________________________________or the physician to exercise their best judgment as to the requirements of such diagnosis and treatment. It is further understood that reasonable effort be made to contact parents/guardians or emergency contact prior to using this consent.

I/we hereby authorize any hospital or physician which has provided treatment to the above named minor to surrender physician custody of such minor to the above agent upon completion of treatment.

This consent shall remain in continuous effect until revoked in writing and delivered to the above named school or organization entrusted with the custody of said minor, or through the specified dates as indicated.

State Date _________________________ Stop Date ___________________

I/we hereby authorize any hospital, physician, or other person who has attended or examined the minor to furnish to the General Conference Insurance Service, or its representative, any and all information with respect to any illness, medical history, consultation prescriptions or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

***We are responsible for any fees incurred not covered by insurance.***

Date_______________ Father____________________________________________

Mother___________________________________________

Guardian_________________________________________

Witness______________________________________________

Notary (if required by state of residence)
Name ____________________________________________________________________________

Date of Birth ______________________________ Social Security Number __________________

Allergies to drugs, food, environmental, insect, etc. (Indicate none if applicable)

___________________________________________________________________________________________

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Immunizations (dates) Hepatitis _________________ Tetanus _____________ Polio _________

Diptheria ______________ Pertussis ________________ HiB________________MMR ___________

Current Medications_________________________________________________________________________

___________________________________________________________________________________________

Parents/Guardians___________________________________________________________________________

Home Address _______________________________________________________________________________
Street Address City State Zip

Home Phone_____________________________________ Mobil Phone _______________________

Work Address _______________________________________________________________________________

Street Address City State Zip

Work Phone _________________________________________________________________________________

Emergency Contact______________________________________ (Relationship)______________

Home Address________________________________________________________________________________
Street Address City State Zip

Work Address________________________________________________________________________________
Street Address City State Zip

Home Phone ____________________Mobile Phone _______________Work Phone___________

Family Physician____________________________________________________________________________

Address_____________________________________________________________________________________
Street Address City State Zip

Phone Number _________________________________________________

Insurance __________________________________________________________________________________

Name of Policy Holder ______________________________________________________________________