K-8 Adventist Education

Continuing Consent to Treatment & Authorization to Release Information

Student Name: _____ Date of Birth: _____

Family Doctor: _____ Phone: (_____) _____ - _____

In case of an emergency, we, the undersigned parents or guardian of the above-named student, a minor, do hereby 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 physician the school or organization may call, whether such diagnosis or treatment is rendered at the office of said physician or at a licensed hospital. It is understood that reasonable effort will be made to contact the parents(s) and doctor listed above before any other physician is called by the school or organization.

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 Spokane Valley Adventist School or the physician to exercise their best judgment regarding the requirement 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 custody of said minor.

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 photocopy of this authorization shall be considered as effective and valid as the original.

Parent Signature: _____ Date: _____ Phone: (_____) _____ - _____

Guardian Signature: _____ Date: _____ Phone: (_____) _____ - _____

Emergency Contact Name: _____ Phone: (_____) _____ - _____