Springs Adventist Academy

2018-2019 Consent to Treat

I, the undersigned parent or guardian of _____, a minor, does consent to any medical transportation, emergency examination, anesthetic, medical or surgical diagnosis or treatment and hospital services that may be rendered to said minor under instruction of the attending physician. It is understood that reasonable effort will be made to contact the parent or guardian or other emergency contact listed below. It is also understood that this consent is given in advance of any specific diagnosis or treatment being required but is given to encourage Spring Adventist Academy and said physician to exercise his best judgment as to the requirements of such diagnosis or treatment. I also understand that I consent to transportation by the school or an ambulance in the case of an emergency.

This consent shall remain in continuous effect until revoked in writing to the school entrusted with the said custody of the minor.

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

_____ _____

Signature of Parent/Guardian Date

_____ _____ _____

Parent/Guardian Contact Phone # Student's Age Student's Birth date

Insurance Company _____ Policy/ID #_____ Group#_____

Name of Preferred Physician_____Phone_____

Name of Dentist_____Phone_____

Please list any allergies _____

Please list any medications student is currently taking_____

Please list any physical handicaps_____

Write any additional information in the space below.

ADDITIONAL EMERGENCY CONTACTS: (Please Print)

NAME:_____PHONE:_____
RELATIONSHIP:

NAME:_____PHONE:_____
RELATIONSHIP: