



Springs Adventist Academy
2019-2020 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: _____