CONTINUING CONSENT TO TREATMENT AND HEALTH INSURANCE INFORMATION

SHENANDOAH VALLEY ADVENTIST ELEMENTARY SCHOOL

CONTINUING CONSENT TO TREATMENT

We, the undersigned parents or guardians of (child's name)_____ 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 (child's physician) _____ , M.D., or any physician the school 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 doctor listed above before any other physician is called.

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 Shenandoah Valley Adventist Academy or the physician to exercise their best judgment as to the requirements 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 entrusted with the custody of said minor.

The above named student ❑ is ❑ is not covered by health insurance.

Present Health Insurance Company _____ Policy Number: _____

SIGNATURE:

DATED: _____ PARENT/LEGAL GUARDIAN: _____

CONTACT INFORMATION

	FATHER/GUARDIAN	MOTHER/GUARDIAN
NAME:		
CELL PHONE #:		
DAYTIME PHONE #:		

PHYSICIAN'S PHONE #: _____

MEDICAL INFORMATION FOR CHILD

Known Allergic Reactions to (medications, bandage materials, perfume, etc.):

_____

_____

_____

Medical Conditions and Medications Taken (such as asthma, heart, etc.):

_____

_____

_____