Continuing Consent for Treatment and Health Insurance Information

Northern New England Conference of Seventh-day Adventists

We, the undersigned parents or guardian of _____, a minor, do
Name of Student
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.,
Name of Physician/s
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 doctor listed above before the school or other organization calls any other physician.

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 _____ or the physician to exercise their
Name of organization into whose custody minor is entrusted
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 the school or organization entrusted with the custody of said minor.

Please list any allergies your child may have: _____

Please list any medications your child is taking:

_____

Please list any medical history your child may have (ie: asthma, seizures, etc.):

_____

The above named student:

- ❑ Is *not* covered by health insurance.
- ❑ Is covered by health insurance

Health Insurance Company: _____
Policy Number: _____

Father's Name/Legal Guardian	Employed at	Work Telephone #
Mother's Name/Legal Guardian	Employed at	Work Telephone #
Home Address		Home Telephone #

If neither Parent/Legal Guardian listed above can be contacted in an emergency, please contact:

Name	Telephone #

Parent/Guardian Signature: _____ Date: _____

Witness: _____ Date: _____