Cypress Bend Adventist Elementary School

CONTINUING CONSENT TO TREATMENT

We, the undersigned parents/guardians of (first name) _____(last name)_____ a minor, do hereby consent to any x-ray examination, anesthetic, medical of surgical diagnosis or treatment that any hospital service may render to said minor under the general or special instructions of the school personnel, whether said diagnosis or treatment is rendered at the office of said physician/dentist or at a licensed hospital.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given to encourage the school personnel and said physician/dentist to exercise his/her best judgment as to requirements of such diagnosis or treatment.

It is also understood that every possible attempt will be made to contact the parents first; only in case of extreme emergency and failure in attempting to contact the parents will this apply.

(father)	(home phone)	(business/cell)
(mother)	(home phone)	(business/cell)
(legal guardian)	(home phone)	(business/cell)
(alternate person to contact)	(home phone)	(business/cell)

OTHER INFORMATION: Allergies, special medical problems, etc. _____

_____

PERSONAL PHYSICIAN INFORMATION:

_____ _____

(Name of Physician/Dentist) (Location of Practice)

_____ _____

(Business Phone) (Hospital)

_____ _____

(Signature of Parent/Guardian) (Date of Signature)