

Continuing Consent to Treatment

We, the undersigned parents / guardians of **(student name)** _____, a minor, do hereby consent to any x-ray examination, anesthetic, medical or 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 judgement as got 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.

	Name	Phone
Father		
Mother		
Legal Guardian		
Alternate Contact		

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