WHISPERING PINES SEVENTH-DAY ADVENTIST SCHOOL **WHISPERING PINES SEVENTH DAY ADVENTIST SCHOOL** WHISPERING PINES SEVENTH-DAY ADVENTIST SCHOOL

CONTINUING CONSENT TO TREATMENT AND HEALTH INSURANCE INFORMATION

We, the undersigned parents or guardians of _____ , 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 _____ , M. D., or any physician summoned by the Whispering Pines Seventh-day Adventist School or any party authorized to act on its behalf (hereafter referred to as "the School"), whether such diagnosis or treatment is rendered at the office of said physician or at a licensed hospital. It is understood that the School will make a reasonable effort 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 authorizes the School or the physician to exercise their best judgment regarding requirements of such diagnosis or treatment.

This consent shall remain in continuous effect until revoked in writing and delivered to the above-named physician and the School.

The above-named student (*CHECK ONE*) is ____ is not ____ covered by health insurance.

Name of current health insurer _____

Policy # _____

_____ _____

FATHER'S SIGNATURE MOTHER'S SIGNATURE

_____

SIGNATURE OF WITNESS

Date: _____