HILLCREST SEVENTH-DAY ADVENTIST SCHOOL
Consent to Treat
(separate form required for each student)

Authorization to Release Information

We, the undersigned parent(s) or guardian(s) 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 instruction of the doctor listed below, or any physician the school or treating 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 parents, guardian, or alternate emergency contacts prior to any medical intervention, and reasonable effort will be made to contact the physician listed below before any other physician is called by the school or other organization. If a dentist is needed, the one listed below will be called.

Physician's Name: ____ **Phone:** ________________________________

Dentist's Name: ____ **Phone:** ________________________________

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 Hillcrest SDA School 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 and to the school or organization entrusted with the custody of said minor.

If Hillcrest desires financial help from the General Conference Insurance Service for school related injuries or illnesses, we hereby authorize any hospital, physician, or other person who has attended or examined the minor to furnish the General Conference Insurance Service or its representative, any and all information, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records related to that injury or illness.

A photo static copy of this authorization shall be considered as effective and valid as the original.

Student Allergies (please list)	**Life Threatening?**	**Other Medical Conditions** (please list)	**Life Threatening?**
	☐Yes ☐No		☐Yes ☐No
	☐Yes ☐No		☐Yes ☐No
Treatment for Allergies:		**Treatment for Medical Conditions:**	

Medical Insurance Company Name ____ Policy Number_______________

Student Name:			Birth Date:
Student Address:	City:	State:	Zip:
Student Home Phone:			
Mother Cell:	Mother Work:	Father Cell:	Father Work:

If our student requires prescription medication, we consent to administration of that medication by Hillcrest.

Emergency Contact *(Person to contact when parent/guardian is NOT available):*

Name:		Relation:
Cell Phone:	Work Phone:	Home Phone:
Name:		Relation:
Cell Phone:	Work Phone:	Home Phone:

Parent/Legal Guardian Signature ____ Date_______________

Revised 4-3-18 **(this form to be kept in teacher's emergency binder)**