CONTINUING CONSENT TO TREATMENT
AND
AUTHORIZATION TO RELEASE INFORMATION
Deamude Adventist Christian School – (801) 731-3140

We, the undersigned parents or guardians of, _____,
(Name of Student)
a minor, do hereby consent to any medical or dental treatment, including x-ray examination, anesthetic, medical/dental 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)
or _____, D.D.S., or any physician/dentist the school or organization
(Name of Dentist)
may call, whether such diagnosis or treatment is rendered at the office of said physician/dentist 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/dentist.

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 ***Deamude Adventist Christian School*** *or the physician/dentist 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 school or organization entrusted with the custody of said minor.

We hereby authorize any hospital, physician, dentist or other person who has attended to or examined the minor to furnish to Adventist Risk Management, Inc. or its representative any and all information with respect to any illness, medical history, dental history, consultation, prescriptions or treatment, and copies of all hospital or medical/dental records. A photo or fax copy of this authorization shall be considered as effective and valid as the original.

Dated: _____ Father's Signature _____

Phones Mother's Signature _____
Home: _____
Work: _____ Guardian's Signature _____

Cell: Mother: _____ Father: _____

In case of an emergency (if unable to reach parent or guardian) please contact:

Name: _____
(Person not living in same home as Parent/Guardian)

Address: _____

_____

Phone: Home: _____ **Work:** _____

Cell Phone: _____ **Physician's Phone:** _____

(Registration Form revised 4/10)