Ruth Murdoch Elementary School
8885 Garland Avenue, Berrien Springs, MI 49104
Phone#: (269) 471-3225 Fax#: (269) 471-6115

2020-2021

CONTINUING CONSENT TO MEDICAL TREATMENT AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

We, the undersigned parents/guardians of _____, **a minor**, do hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital service which may be rendered to said minor under the general or special instructions of _____, **our family physician**, or any physician the school 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 physician listed above and/or the parents or guardian before any other physician is called by the school.

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 Ruth Murdoch Elementary 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 for the duration of this student's enrollment unless revoked in writing and delivered to Ruth Murdoch Elementary School's office.

We, hereby, authorize any hospital, physician, or other medical personnel who has attended or examined the minor to furnish to _____, **our insurance company**, or its representative, any and all information with respect to any illness, medical history, consultation, prescriptions, or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered as effective and valid as the original.

INFORMATION WHICH MAY BE IMPORTANT IN AN EMERGENCY: (answer #1 – 4 and A-D)

1. Student's Date of Birth _____ / _____ / _____

2. **Medication(**s) that the student takes regularly:

3. **Allergic reactions** to specific medications, foods, or physical contact with various natural or artificial matter:

4. **Medical conditions** such as diabetes, convulsions, asthma, etc. about which the attending physician should know in advance of diagnosis or treatment.

A. _____ _____ _____
Printed Name of *Father*/Legal Guardian **Signature of *Father*/Legal Guardian** **Date**

B. _____ _____ _____
Printed Name of *Mother*/Legal Guardian **Signature of *Mother*/Legal Guardian** **Date**

C. _____ _____ _____
Printed Name of OTHER Adult Witness **Signature of OTHER Adult Witness** **Date**

D. (_____)_____ (_____)_____(_____)_____
Family Physician's Telephone Number **Parents/Guardian's Telephone Number(s)**