JOHN L. COBLE ELEMENTARY SCHOOL

Consent to Treatment
Authorization for Medical Treatment for Minors

I, _____ (print name of parent or guardian) am the parent or legal guardian of _____ (print name of minor), referred to as "my child."

My child is attending and participating in activities at John L. Coble Elementary School, a Seventh-day Adventist entity, located at 450 Academy Drive SW, in the city of Calhoun, Gordon (County), Georgia (State).

I authorize the Director/Administrator and his/her officers, employees, or volunteers who are 21 years of age or older, who supervise the activities at this organization into whose care my child has been entrusted, to consent to medical or dental care, or both, for my child.

The authority granted by this authorization includes the authority to consent to any radiological (x-ray) examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician and surgeon, licensed under state laws, for my child.

I further authorize the Director/Administrator and his/her officers, employees, or volunteers who supervise the activities of the organization to receive physical custody of my child upon completion of any treatment, and I specifically instruct any treating health facility to surrender custody of my child to the Director/Administrator and his/her officers, employees, or volunteers who are 21 years of age or older who supervise the activities at this organization.

It is understood that this authorization is given in advance of any special diagnosis, treatment, or required hospital care, but is also given to provide authority and power on the part of the Director/ Administrator and their authorized designee, to exercise their best judgment on what is advisable for my child's care, upon advice of such physician, dentist and surgeon. A photocopy of this authorization shall be as valid as the original. This Authorization shall remain valid until revoked in writing.

The attached information sheet contains the complete and accurate health and emergency information to assist in providing assistance to my child.

Signed:

Father _____ Date:_____/_____/_____

Mother_____ Date:_____/_____/_____

Legal Guardian _____ Date:_____/_____/_____

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Health and Emergency Information

My Child's Information			Date
Legal Name			
First	Middle	Last	Date of Birth
Emergency Phone Numbers			
Home Phone	Work Phone		Cell Phone
Address			
Street	City		State
Health Insurance (Please attach a photocopy of the health insurance card)			
Primary Insured	Insurance Company		Group Number
Is the child now being or has the child ever been treated by a physician for an allergy? If so, when and for how long?			
List foods below that are NOT to be served to the child:			
What reaction does the child have when these foods are eaten?			
Is the child allergic to any medications? If so please list below.			