CONTINUING CONSENT TO TREATMENT
AND
AUTHORIZATION TO RELEASE INFORMATION
Lewis County Adventist School – (360) 748-3213

We, the undersigned parent(s) or guardian(s) 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 transportation by ambulance for hospital service that may be rendered to said minor under the general or special instructions of

_____, M.D., Phone: _____
(Name of Physician)
_____, D.D.S., Phone: _____
(Name of Dentist)

or any medical or dental professional the school or hospital may call, whether such diagnosis or treatment is rendered at the office of said medical or dental professional 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 medical or dental professional.

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 ***Lewis County Adventist 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: _____

MEDICAL INFORMATION

Student Name: _____ **Birth Date**: _____

Does Student have **ASTHMA**? (Check one) Yes ___ No ___
*(**If yes** please fill out "Asthma Individual Health Plan" form obtained from office)*

Does Student have to take **medication** during the school hours? (Check one) Yes ___ No ___
*(**If yes** please obtain "Authorization for Administration of Medication at school" form from office)*

MEDICATION PERMISSION

The school secretary, or other designated school personnel, has my permission to administer Tylenol to my child on an as-need basis. (Check one) Yes ___ No ___

_____
Parent's Signature Authorizing Permission to Administer Tylenol

MEDICAL HISTORY

Date	Condition	Description

ALLERGIES

Type	Description

IN CASE OF EMERGENCY CALL (Other than Parents):

NAME:_____Relationship to student _____

Phone: Home: _____Work: _____Cell: _____

This person has permission to pick up the above named child and take from LCAS campus: YES ___ NO ___ (Check answer)

NAME: _____ Relationship to student: _____

Phone: Home:_____Work:_____Cell: _____

This person has permission to pick up the above named child and take from LCAS campus: YES ___NO _____(Check answer)

Today's Date: _____