Louisville Adventist Academy
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LAA CONSENT FOR TREATMENT FORM
2016-2017

I/we the undersigned parent(s) or legal guardian(s) of _____, a minor, do hereby consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital services that may be rendered to said minor under the general or special supervision of any physician and surgeon, licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at the licensed hospital. It is understood that reasonable effort will be made to contact the doctor listed before any other physician is called by the school or other organization.

It is further understood that this consent is given in advance of any specific diagnosis, treatment or hospital care which might be required, but is given to provide authority to Louisville Adventist Academy or the physician to exercise their best judgment as to the requirements of such diagnosis and treatment. It is further understood that reasonable effort will be made to contact parents/guardians or emergency contact prior to using this consent.

I/we hereby authorize any hospital or physician which has provided treatment to the above-named minor to surrender physician custody of such minor to the above agent upon completion of treatment.

This consent shall remain in continuous effect until revoked in writing and delivered to the above-named school or organization entrusted with the custody of said minor, or through the specified dates as indicated.

Start Date _____ Stop Date _____

I/we hereby authorize any hospital, physician, or other person who has attended or examined the minor to furnish to the General Conference Insurance Service, 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.

We are responsible for any fees incurred not covered by insurance.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date

>>>Please turn over to reverse side to complete Medical Information.>>>

Medical Information

Name of Student _____

Date of Birth ____/____/____ Social Security Number ____-____-____

Allergies to drugs, food, environment, insects, etc. (Indicate none, if applicable) _____

_____

_____

_____

Immunizations (dates) Hepatitis _____ Tetanus _____ Polio _____

Diphtheria _____ Pertussis _____ HiB _____ MMR _____

Current Medications _____

_____

Parent(s)/Guardian(s) _____

Home Address _____ Work Address _____

_____ _____

Phone _____ Phone _____

Emergency Contact _____ Relationship _____

Home Address _____ Work Address _____

_____ _____

Phone _____ Phone _____

Family Doctor _____

Address _____

Phone _____

Insurance _____ Name of Policy Holder _____