Consent for Medical/Surgical Care, Emergency Treatment and Health Insurance Information

We, the undersigned parent or guardian of _____ a minor, do hereby voluntarily consent to the rendering of such care including diagnostic procedures, surgical and medical treatment, and blood transfusions by authorized members of the hospital staff or their designee, as may in their professional judgement be necessary.

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 the Manassas Adventist preparatory school or the physician to exercise their best judgement as to the requirements of such diagnosis or treatment to prevent the help of my(our) child.

I hereby acknowledge that no guarantees have been made to me as to effect of such examinations for treatment of my child's condition.

This consent shall remain in continuous effect until revoked in writing and delivered to the physician named below or to the school and entrusted with the custody of said minor.

We /I acknowledge that we are (I am) responsible for all reasonable charges in connection with the care and treatment rendered during this period.

The above named student **( )** is **( )** is not covered by health insurance.

Name of Health Insurance Carrier:_____
Member No: _____Group No:_____
Pediatrician and phone No :_____
Family Physician and Phone No:_____
Dentist and Phone No: _____
Child allergies, if any:_____
Known Medical Problems:_____
Medicine(s) Child is Taking and_____
Dosage*:_____

_____ _____
Father and/or Mother Date

_____ _____
Guardian Date

_____ _____
Witness Date

In case of emergency, I can be reached at: _____

*If student is taking regular medication during school hours please get medical administration been completed and signed by your physician.