Louisville Adventist Academy

2988 Newburg Road
Louisville, KY 40205

RELEASE AND CONTINUING CONSENT FOR EMERGENCY MEDICAL TREATMENT

Student _____ SSN _____
Last First Middle

Address _____
Street / P.O. Box City State Zip

Home Telephone _____ Age _____ Date of Birth _____

MEDICAL INFORMATION

Student allergies to medicine or other:

_____

_____

_____

Any special medical/physical problems (i.e., asthma, diabetes, recent surgery, chronic illness, etc.):

_____

_____

_____

Is he/she now taking any medication, if so, please specify:

_____

_____

_____

Send all necessary prescription medications to school and on trips, especially asthma and diabetes medications.

Family Doctor: _____

Family Doctor Telephone: _____

Parent/Guardian Names: _____

Father's work #: _____

Father's Cell #: _____

Mother's work #: _____

Mother's Cell #: _____

Health Insurance Company:

_____

Policy #: _____

Group #: _____

Name of Policy Holder: _____

Emergency Contacts (other than parents):

Name: _____

Phone number: _____

Name: _____

Phone number: _____

Louisville Adventist Academy has my permission for any necessary EMERGENCY TREATMENT, including consent to any X-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital service that may be rendered to the above stated minor under the general or specific instructions of the above stated physician or any physician the Louisville Adventist Academy may call, whether such diagnosis or treatment is rendered at the office of said physician or at a licensed hospital. Reasonable effort will be made to contact the parents/guardians of the injured student, and the doctor listed above before any other physician is called by Louisville Adventist Academy.

This consent is given in advance of any specific diagnosis or treatment which might be required and to authorize the Louisville Adventist Academy and the physician to exercise their best judgment as to the requirements of such diagnosis or treatment.

This consent is in continuous effect through the 2019-2020 school year. It is delivered to the physician/hospital caring for the child and to the Louisville Adventist Academy entrusted with the custody of said minor.

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 photo copy of this authorization shall be considered as effective and valid as the original.

We are responsible for any fees not covered by insurance.

Date: _____

Parent/Guardian Signature: _____

STATE OF KENTUCKY, JEFFERSON COUNTY

The following was acknowledged before me this _____day

of_____, 20_____,

by _____.
(name of parent/guardian).

_____
Notary Signature

Notary Stamp

____ Personally known OR _____Produced Identification