Indiana Conference of Seventh-day Adventists Schools

Continuing Consent to Treatment

We, the undersigned parent(s) or guardian(s) of _____, a
Full Legal Name of Student and Date of Birth

minor, do hereby consent and authorize _____ and its representatives
Name of School

to secure any medical and/or surgical diagnosis or treatment and/or other medical procedures that may be required by said minor in the event of accident or other reason which may require medical treatment in the sole discretion of _____ and its representatives.
Name of School

The school may call any licensed physician/dentist and such diagnosis or treatment may be rendered at said physician's/dentist's office or a licensed hospital or any other place, and the undersigned agrees to pay the cost of such care and to hold harmless _____ for all expenses of such
Name of School

services and for any other liability in procuring such service. The undersigned requests that if possible the following physician/dentist be contacted for the purpose of rendering such diagnosis or treatment:

_____, M.D. _____, D.D.S.
Preferred Physician *Preferred Dentist*

It is understood that this consent is given in advance of any specific diagnosis or treatment which might be required. This consent shall remain in continuous effect until revoked in writing and such revocation delivered to

_____.
Name of School

The following information is needed by any physician or hospital not having access to the minor's medical history:

Allergies: _____

Current Medications: _____

Date of Last Tetanus Shot: _____

Physical Impairments: _____

The above name minor _____ is _____ is not covered by Health Insurance.

Present Health Insurance Company: _____

Policy Number: _____

The following must be witnessed:

_____ _____
Signature *Title (Father, Mother, or Legal Guardian)*

_____ _____
Printed Name *Date*

_____ _____ _____
Signature of Witness *Printed Name* *Date*

Revised 06/21/2016