



Continuing Consent to Treatment and Authorization to Release Information

I, the undersigned parent/guardian of the above named student, do hereby consent to any x-ray, examination, anesthetics, medical or surgical diagnosis or treatment, and hospital service that may be rendered to said minor under the general or special instruction of the above named physician or a licensed hospital. It is understood that reasonable effort will be made to contact the physician listed above before any other physician is called.

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 school or the physician to exercise their best judgment as to the requirement of such diagnosis or treatment.

This consent shall remain in continuous effect until revoked in writing and delivered to the physician named above or the school.

I hereby authorize any hospital, physician, or other person who has attended or examined the minor to furnish to the student's accident insurance carrier or its representative any and all information with respect to any illness, medical history, consultation, x-ray, or treatment, and copies of all hospital or medical records. A copy of this authorization shall be considered as effective and valid as the original.

Signed: _____ Date: _____

Witness: _____ Date: _____

