



CONTINUING CONSENT TO TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

Parents/Guardians: In the event your child becomes ill or injured during the school day or school related event or field trip, and you cannot be reached, this authorization form gives consent for medical treatment to be administered to your child. **While we always will attempt to contact parent/guardians first, this authorization is needed to have EMS transport your child to the hospital in an emergency.** Please complete this form for each individual child.

First Name	Middle Name	Last Name	Date of Birth
List any allergies and reactions		List any medications the student takes	
List name of medical insurance if any		List any other medical concerns	

Emergency contacts (please include legal guardians)

Name	Relationship to child	Phone number
Name	Relationship to child	Phone number
Name	Relationship to child	Phone number

<input type="checkbox"/> I consent to medical treatment of my child and authorize release of information.	<input type="checkbox"/> I do not want my child to receive any medical treatment without my explicit consent.
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If marked I **consent** above:

I, the undersigned parents or guardians of the minor listed above do hereby consent to any medical examination, treatment, diagnosis, or hospital service that may be rendered to said minor(s) under the general or special instructions of any emergency physician or physician the school may call, whether such diagnosis or treatment is rendered at the office or said physician or at a licensed hospital. It is understood that all reasonable effort will be made to contact the parent/guardian and the doctor of choice before any other physician or emergency service is called.

It is further understood that this consent is given in advance of any specific diagnosis or treatment which may be required and is given to authorize Columbus Adventist Academy or the physician to exercise their best judgement as to the requirements of such diagnosis or treatment.

We hereby authorize any hospital, physician, or other person who has attended or examined the minor to furnish the school 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 reports. A photocopy of this authorization shall be considered as effective and valid as the original. This consent shall remain in effect until revoked in writing and delivered to school entrusted with minor.

Name of Parent/Guardian

Signature of Parent/Guardian

Date