# CONSENT FOR MEDICAL TREATMENT

PORTLAND ADVENTIST ACADEMY

**PLEASE COMPLETE EACH LINE IN BLACK INK SO PHOTOCOPIES ARE LEGIBLE**

I, the undersigned parent or guardian of ________________________, a minor, do hereby consent to any x-ray examination,
(student name-last, first, middle)
immunization, anesthetic, medical or minor surgical diagnosis or treatment and hospital service that may be rendered to the said minor under the general or specific instructions of a physician. In the event of serious illness, the need for major surgery, or significant accidental injury, I understand that an attempt will be made by the attending physician to contact me so that the treatment necessary for the best interest of the above named student may be given.

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 nurse or other designated personnel of Portland Adventist Academy or 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 Portland Adventist Academy. I hereby authorize any hospital, physician or other person who has attendant the minor to furnish the insurance service or its representative any information with respect to any illness, medical history, consultation, prescriptions, or treatment and copies of all hospital or medical records. A photo-static copy of this authorization shall be considered as valid as the original.

_______________________________________________________ _________________________

SIGNATURE OF PARENT/GUARDIAN DATE

**STUDENT NAME** __________________________________ _______ __________ ______________

Grade Birth date Social Security

________________________ ______________________________________________________________________

Date of last tetanus booster Medical Allergies

_____________________________________________________________________________________________

Other Pertinent Medical Information

**Family Physician:** ____________________________________ **Phone Number:** ____________________________________

**Father:** ______________________________________ **Mother:** ______________________________________

_____________________________________________ _____________________________________________

Address Address

_____________________________________________ _____________________________________________

City State Zip City State Zip

(_____)______________ (_____) ________________ (_____)______________ (_____) ________________

Home Phone Work Phone Home Phone Work Phone

***EMERGENCY CONTACT—OTHER THAN PARENT OR GUARDIAN***

Name___________________________________ Home Phone_____________________________________

Address_________________________________ Work Phone _____________________________________

City, State, Zip___________________________ Cell Phone ______________________________________

Insurance Information:

_____________________________________________________________________________________________

Name of Carrier Policy Holder Policy Number Group Number

_____________________________________________________________________________________________

Address Phone Number Employer Referral needed?

_____________________________________________________________________________________________

Preferred Provider Plan? Primary care Physician Primary care office phone #