

MILWAUKEE SEVENTH-DAY ADVENTIST SCHOOL

**CONTINUING CONSENT TO TREATMENT
AND HEALTH INSURANCE INFORMATION
(On Campus)**

We, the undersigned parents or guardian of _____,
Name of student or member

a minor, do hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered to said minor under the general or special instruction of _____, M.D., or any physician the school or

Name of Physicians

organization may call, whether such diagnosis or treatment is rendered at the office of said physician or at a licensed hospital. It is understood that reasonable effort will be made to contact the doctor listed above before the school or other organization calls any other physician.

It is further understood that this consent is given in advance of any specific diagnosis or treatment that might be required and is given to authorize Milwaukee Seventh-day Adventist School or the physician to exercise their best judgment as to the requirements of such diagnosis or treatment.

This consent shall remain in continuous effect until revoked in writing and delivered to the physician named above or to the school or organization entrusted with the custody of said minor.

The above named student is ____, is not ____ covered by health insurance.

Present Health Insurance Company _____

Policy Number _____

Signature of Father

Date

Signature of Mother

Date

Signature of Guardian

Date

Parents Names: _____

Address: _____

Phone – Father - home () _____ work () _____ Cell () _____

Phone – Mother - home () _____ work () _____ Cell () _____