

**CONTINUING CONSENT TO TREATMENT  
AND HEALTH INSURANCE INFORMATION**

We, the undersigned parents or guardian of, \_\_\_\_\_(student) 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 instructions of \_\_\_\_\_(name of physician), M.D., or any physician the school or 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 any other physician is called by the school or other organization.

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 **Spring Creek Adventist School** or the physician to exercise their best judgment as to the requirements of such diagnosis or treatment.

The 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:** \_\_\_\_\_

**Dated:** \_\_\_\_\_

\_\_\_\_\_  
Father

\_\_\_\_\_  
Mother

\_\_\_\_\_  
Legal Guardian