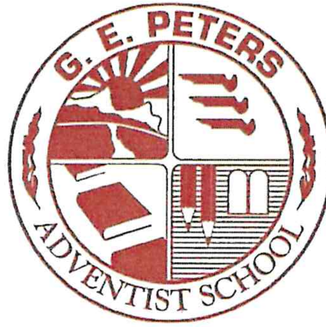


**CONSENT TO TREATMENT AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

We, the undersigned parents/guardians of ________________________________ a minor, do hereby consent
*Name of Student*

to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital service that may

render to said minor under the general or specific instructions of ______________________ or any physician the
*Name of Physician*
school or organization may call, whether such diagnosis or treatment is rendered at the office or the 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 a specific diagnosis or treatment which might be required and is given to authorize G.E. Peters Adventist School, or the physician, to exercise their best judgment as to the requirement 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 custody of said minor.

We hereby authorize any hospital, physician, or other person who has attended or examined the minor to furnish G. E. Peters Adventist School, or its representative, any and all information with respect to any illness, medical history, consultation, prescriptions or treatment, and copies of all hospital and/or medical records. A PHOTOSTAT COPY of this authorization shall be considered effective and valid as the original.

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|---|---|
| ________________________________ | ________________________________ |
| Signature of Mother/Guardian | Signature of Father/Guardian |
| ________________________________ | ________________________________ |
| Date | Witness Name & Signature |
| ________________________________ | ________________________________ |
| Physician's Name | Physician's Contact Number |