

# ATHOLTON ADVENTIST SCHOOL

## CONTINUING CONSENT TO TREATMENT AUTHORIZATION TO RELEASE INFORMATION

6520 Martin Road ● Columbia, MD 21044 ● Phone 410-740-2425 ● Fax 410-740-2545

We, the undersigned parents or guardian of \_\_\_\_\_, 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  
\_\_\_\_\_, 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 Atholton 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.

We hereby authorize any hospital, physician or other person who has attended or examined the minor  
to furnish to 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 Photostat copy of this authorization shall be considered as effective and as valid as the  
original.

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Dated

\_\_\_\_\_  
Witness

<b>Medical Information</b>	<b>Name</b>	<b>Policy #</b>	<b>Group #</b>
Insurance			
<b>Medical Information</b>	<b>Name</b>	<b>Phone</b>	<b>Address</b>
Healthcare Provider			
Dentist			
Allergies			
Medication			