

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

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 and 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 **COLLEGEDALE ACADEMY** 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 covered by Health Insurance

_____ is NOT covered by Health Insurance

The above named student
_____ is allergic to medication

_____ is NOT allergic to medication

Present Health Insurance Company

Policy Number

Medications allergic to

Home Phone

Home Mailing Address

City/State/Zip

Father's Signature

Father's work phone

Mother's Signature

Mother's work phone

Legal Guardian's Signature

Guardian's work phone

Witness

DATED: _____