



## Parental Consent for Medical treatment and Release of Information

We, the undersigned parent or guardian of \_\_\_\_\_ a minor, do hereby consent to any x-ray examination, anesthetics, medical or surgical diagnosis, or treatment and hospital service that may be rendered to said minor under the general or special instruction of \_\_\_\_\_, MD, 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 Lithonia Adventist Academy or the physician to exercise their best judgement as to the requirement of such diagnosis or treatment. This consent shall remain in continuous effect until revoked in writing and delivered to the physician named above or the school organization entrusted with the custody of said minor. We hereby authorize any hospital, physician, or other people who has attended or examined the minor to furnish to General Conference Insurance Service, or its representative, all information with respect to any illness, medical history, consultation, prescriptions, or treatments and copies or all hospital or medical records, A photo static copy of this authorization shall be considered as effective and valid as the original.

\_\_\_\_\_  
Father

\_\_\_\_\_  
Date

\_\_\_\_\_  
Mother

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Date