# Atholton Adventist Academy

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

## Medical Consent to Treatment
## Authorization to Release Information

We, the undersigned parents or guardian of _____, a minor, do hereby
Name of Student
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 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.

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

| Medical Information | Name | Policy # | Group # |
|---|---|---|---|
| Insurance | | | |
| **Medical Information** | **Name** | **Phone** | **Address** |
| Doctor | | | |
| Dentist | | | |
| Allergies | | | |
| Medication | | | |