

Salisbury Adventist School
— Emergency Consent to Treatment —

_____ **School Year** _____

Student's Name: _____ **Home Number:** _____

Mother's/Guardian's Name: _____ **Work Number:** _____

Cell Phone/Pager: _____

Father's/Guardian's Name: _____ **Work Number:** _____

Cell Phone/Pager: _____

Doctor's Name: _____ **Office Number:** _____

Choice of Hospital: _____

Present Family Health Insurance Company: _____

Policy#: _____

We, the undersigned parents or legal guardian of the above student do hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital services that may be rendered. It is understood that reasonable effort will be made to contact the parent/guardian and the doctor listed above before any other physician is called by the school. It is understood that this consent is given in advance of any specific diagnosis or treatment which might be required.

Parent or Legal Guardian

Date