Consent-Authorization-Emergency Form for Pathfinders

We, the undersigned parents or guardian of ______________________________ , (print name of child) minor, do hereby consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, hospital service, and counseling that may be rendered to said minor under the general or special instructions of any physician the organization may call, whether such diagnosis or treatment is rendered at the office of the physician or at a licensed hospital.

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 ___________________________________ or the physician to exercise their best judgment as to the requirements of such diagnosis or treatment.

Further, we specifically grant all medical providers including hospitals, doctors, laboratories and such related treatment facilities, and their representatives, the right to release and disclose such treatment and healthcare information, including, without limitation, any and all information with respect to any illness, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical records as many be necessary to seek payment for services provided hereunder. Such disclosure may extend to the provider's business office staff, insurance organizations and other businesses that may become involved in the process of billing and collecting unpaid balances. Further, such medical providers are hereby authorized to disclose and/or share healthcare information with other healthcare professionals who may provide treatment and/or service to the student named herein. Such disclosure of healthcare information may extend to informing any representative(s) of the Seventh-day Adventist Church responsible for the student during such healthcare process in order to assist in necessary decisions, arrangements and for informing the undersigned.

This consent shall remain in continuous effect until revoked in writing. A copy of this authorization shall be considered as effective and valid as the original.

Father's Signature
Home Address
Date Home Phone ( ) Business Phone ( )

Mother's Signature
Home Address
Date Home Phone ( ) Business Phone ( )

Legal Guardian's Signature
Home Address
Date Home Phone ( ) Business Phone ( )

If unable to contact Mother, Father, or Guardian, please contact:
Relationship Phone ( )

Insurance Company Policy No.
Insurance Company
Address
Phone No. ( )
Policy Information
Policy Holder's Name

Child's Date of Birth
List any **Allergies** the child has
Date of Last Tetanus Booster
If Dental Work is up to Date, Indicate the Approximate date it was completed
(month, year)
Medication Condition Requiring Medication
Name & Address of Doctor Prescribing
Date Ordered