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CONTINUING CONSENT TO TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

We, the undersigned parents or guardian of _____,
Student's Name
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 or special instructions of _____
Name of Physician or Clinic
at the office of said physician or at a licensed hospital. It is understood that reasonable effort will be made to contact the doctor/clinic 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 that might be required, and is given to authorize **Beacon Christian School** or the physician to exercise their best judgment 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 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's insurance carrier, 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 records. A photocopy of this authorization shall be considered as effective and valid as the original.

Dated: _____

Parents/Legal Guardian Signature _____