



Cypress Adventist School — 21500 Cypress Way, Lynnwood, WA 98036 — 425-775-3578

**Consent for Emergency Medical Treatment:**

I, the undersigned parent/guardian of \_\_\_\_\_, a minor, do hereby consent to x-ray, anesthetic, medical or surgical diagnosis or treatment and hospital services that may be rendered under the general or special instructions of \_\_\_\_\_, MD (phone) \_\_\_\_\_, or any physician the school or organization may call, whether such a 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 Cypress Adventist School 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 General Conference 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 records. A photo copy of this authorization shall be considered as effective and valid as the original.

\_\_\_\_\_  
Parent/Guardian Signature Date

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

<b>MEDICAL INFORMATION</b>	
Does your son/daughter take medication? <input type="checkbox"/> Yes <input type="checkbox"/> No      What Kind? _____	
<b>Parent &amp; Doctor note must accompany <u>all</u> medication. Medication must be brought to the school office in original container.</b>	
Is your son/daughter subject to conditions that may cause classroom emergencies, such as epilepsy, diabetes, fainting, allergies, asthma, other? _____	
Have there been any illness, accidents, operation or congenital defects that limit student's participation in:	
Classroom Activities	<input type="checkbox"/> Yes <input type="checkbox"/> No
Physical Education	<input type="checkbox"/> Yes <input type="checkbox"/> No
Insurance Provider _____, # _____	Hospital _____
Primary Care Physician _____	Phone _____