Mills River Seventh-day Adventist School
2142 Jeffress Road, Mills River NC 28759
Phone: 828-785-2319; Fax: 828-891-2021

EMERGENCY CONSENT TO TREATMENT

Student(s) Name(s) ____

Home Phone _______________________

Mother's Name_______________________ Work Phone _______________________

Cell Phone _______________________

Father's Name________________________ Work Phone _______________________

Cell Phone ________________________

or

Legal Guardian _______________________ Work Phone _______________________

Cell Phone _______________________

Doctor's Name ________________________ Office Phone ______________________

Choice of Hospital ______________________

We, the undersigned parents or legal guardian of the above student(s), 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.

Present Family Health Insurance Company ____

Policy #____________________________

Signature of Parent or Legal Guardian

____

Print Name _________________________________ Date ___________________