Continuing Consent to Treatment and Authorization to Release Information
20___ - 20___

We, the undersigned parent (s) or guardian (s) of _____ 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 the doctor listed below, or any physician the school may call, whether such 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 below before any other physician is called by the school.

Physician's Name: _____ Phone: _____
Dentist Name: _____ Phone: _____

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 Hermiston Junior Academy or the physician to exercise their best judgment of such diagnosis or treatment.

This consent shall remain in continuous effect for one year or until revoked in writing and delivered to Hermiston Junior Academy.

We hereby authorize any hospital, physician, or other person, who has attended or examined the minor, to furnish the student's accident 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.

Parent/Legal Guardian Signature _____ Date _____

Student Allergies: _____

Other medical conditions: _____