ATLANTA NORTH SCHOOL
SHAPING LIVES FOR SUCCESS

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CONTINUING CONSENT TO TREATMENT AND HEALTH INSURANCE INFORMATION

We, the undersigned parents or guardian of (Name of Student or Member) _____, a minor, do hereby consent to any emergency x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered to said minor. It is understood that reasonable effort will be made to contact the student's doctor.

It is further understood that the school is authorized and will seek medical treatment in a perceived emergency. This consent is given in advance of any specific diagnosis or treatment which might be required and is given to authorize Atlanta North School or the physician to exercise their best judgement as to the requirements of such diagnosis or treatment.

This consent shall remain in continuous effect until revoked in writing and delivered to the school or organization entrusted with the custody of said minor.

The above named student
( ) is
( ) is not
covered by health insurance.

Present Health Insurance Company: _____
Policy Number: _____

Is this student currently taking any medications? □ No □ Yes
Explain: _____

Does this student have any allergies? □ No □ Yes
Explain: _____

Mother's Signature: _____ Date: _____
Father's Signature: _____ Date: _____
Legal Guardian's Signature: _____ Date: _____