Mount Ellis Elementary

Student Name:_____

First Name Last Name

Grade:_____

Address:_____

_____

Phone Number:_____ Relationship:_____

Allergies/Medications:_____

_____

_____ I give permission for Mt. Ellis Elementary to use photos of my child on recruitment material or for the yearbook.

_____ I want to be notified in future combined events that Mt. Ellis Elementary may have.

CONSENT TO TREAT:

We, the undersigned parent(s) or legal guardian(s) of the minor named above, hereby give our consent for any X-ray, examination, anesthetic, medical, or surgical diagnosis or treatment that may be deemed necessary. This includes any hospital services that may be rendered to the minor under the general or special instructions of the physician listed, or any physician selected by Mt. Ellis Elementary School. This consent applies whether such diagnosis or treatment is provided in the physician's office or at a licensed hospital. It is understood that reasonable effort will be made to contact the parents and doctor listed before any other physician is called by the school and treatment has begun. 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 Mt. Ellis Elementary school the physician to exercise their best judgment as to the requirement of such diagnosis or treatment. We, hereby authorize any hospital, physician or other person who has attended or examined the minor to turn to the General Conference Insurance Service or its representative, any or all information with respect to illness, medical history, consultation, prescriptions, or treatment and copies of all hospital and medical records. A photocopy of the authorization shall be considered as effective and valid as the original.

Signature_____ Date_____