Mills River SDA School

2142 Jeffress Rd.

Mills River, NC 28759

EMERGENCY CONSENT TO TREATMENT

Student(s) Name(s): _____

Home Phone: _____

Mother's Name: _____

Cell Phone: _____ Work Phone: _____

Father's Name: _____

Cell Phone: _____ Work Phone: _____

or

Legal Guardian _____

Cell Phone: _____ Work Phone: _____

Doctor's Name: _____ Office Phone: _____

Choice of Hospital: _____

We, the undersigned parent(s) 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.

Current Family Health Insurance Company: _____

Policy #: _____

Signature of Parent or Legal Guardian:

_____

Print Name: _____ Date: _____