

## LCA CONTINUING CONSENT TO TREATMENT

We, the undersigned parents or guardians of 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 preferred physician  
\_\_\_\_\_ M.D. or any physician that Lester Coon Adventist  
School (LCA) or an affiliated organization 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 above before any other physician is  
called by LCA or another organization. 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 LCA or the physician evaluating  
the said minor to exercise his or her best judgment as to the requirements of such diagnosis or treatment.

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

### CHECK ONE:

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

Please list name and phone number of health insurance provider:

\_\_\_\_\_

\_\_\_\_\_  
Signature of Father

\_\_\_\_\_  
Signature of Mother

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Legal Guardian

\_\_\_\_\_  
Date