DATE _____

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