Omak Adventist Christian School

P.O. Box 3294, Omak, WA 98841-3294
(509) 826-5341

Consent to Treatment and Authorization to Release Information

We, the undersigned parent or guardian of _____, a 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 _____ M.D. or any physician Omak Adventist Christian School 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 Omak Adventist Christian School.

It is further understood that this consent is given in advance of any specific diagnosis of treatment, which might be required and is given to authorize Omak Adventist Christian School or the physician to exercise their best judgment as to the requirement 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 Omak Adventist Christian School entrusted with the custody of said minor.

We hereby authorize any hospital, physician, or other person who has attended or examined the minor to furnish to General Conference Risk Management, or its representative, any and all information with respect to any illness, medical history, consultation, prescriptions of treatment, and copies of all hospital or medical records. A photocopy of this authorization shall be considered as effective and valid as the original.

Parent or Legal Guardian

Complete Date