

**CONTINUING CONSENT TO TREATMENT AND HEALTH
INSURANCE INFORMATION**

We, the undersigned parents or guardian consent to any x-ray examination, anesthetic, medical or surgical treatment and hospital service that may be rendered to said minor under the general or special instructions of their family or any physician the school or organization may call. It is understood that reasonable effort will be made to contact the family doctor.

It is further understood that this consent is given in advance of any specific diagnosis or treatment which might be required. This authorizes CVA staff or the physician to exercise their best judgment as to the requirements of such diagnosis or treatment.

Physician Name: _____

Address: _____

Phone #: _____

Health Insurance Co.: _____

Policy #: _____

S.S.N.: _____

Allergies:

Food _____

Medical _____

Date of Last Tetanus: _____

Any Pertaining Medical Condition: _____

Parent/Guardian Signature: _____