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PORTLAND CHRISTIAN SCHOOLS
EARLY CHILDHOOD EDUCATION / SCHOOL-AGE

2018-19 AUTHORIZATION FOR TREATMENT

As a parent (or legal guardian) of:

____ , age __________
(Child's full name)

a minor, I hereby authorize and consent to any x-ray examination, anesthetic, medical, or surgical treatment rendered by my family physician listed below, or if my family physician is unavailable, by any member of the medical/dental staff of Portland Adventist Medical Center.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care deemed advisable by the aforementioned physicians in the exercise of their best judgment. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that none of the above treatment will be withheld if the undersigned cannot be reached.

Signature ____

Relationship ____________________________________ Date ________________

Address ____

City _______________________________________ State _________ Zip ________

Birth date of child ____________________ Child's Last Tetanus ____________

List any restrictions ____

This consent shall remain effective until ________**SEPTEMBER 2019**________

Allergies to food or drugs ____

____

Special medications (or) ____

Special medical problems ____

Telephone numbers where parents or guardian may be reached:

Father ____________________ ____________________ ____________________
Home *Cell* *Work*

Mother____________________ ____________________ ____________________
Home *Cell* *Work*

Family Physician __________________________________ Phone ______________

Family Dentist ____________________________________ Phone ______________