Andrews Academy
8833 Garland Ave
Berrien Springs, MI 49104
Phone: 269-471-3138 Fax: 269-471-6368

CONTINUING CONSENT TO MEDICAL TREATMENT AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION
2016-17

PLEASE ATTACH A COPY OF YOUR INSURANCE CARD. (FRONT AND BACK)

We, the undersigned parents/guardians of_____, a minor, do hereby consent to any x-ray examination. Anesthetic, Medical or surgical diagnosis or treatment and hospital services which may be rendered to said minor under the general or special instructions of our family physician,_____, or any physician the 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 physician listed above and/or the parents/guardian before any other physician is called by the school.

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 Andrews Academy or the physician to exercise their best judgment as to the requirements of such diagnosis or treatment. This consent shall remain in continuous effect for the duration of this student's enrollment unless revoked in writing and delivered to Andrews Academy's office.

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

INFORMATION WHICH MAY BE IMPORTANT IN AN EMERGENCY:

Student's Date of Birth: ___/____/_____ **Social Security #_____**

Medication(s) that the student takes regularly	
Allergic reactions to specific medications, foods, or physical contact with various natural or artificial matter	
Medical conditions such as diabetes, Convulsions, asthma, etc. about which the Attending physician should know in advance Of diagnosis or treatment.	
Physician's Name/Office:	
Physician's Phone # & Fax #:	

Does your child require epi-pen? ___Yes ___No If yes, please provide one to the school. _____ Office Initial

	Printed Name & last 4 digits of Social Security #	Signature	Date	Phone #'s
Father/or Legal Guardian				Cell:_____ Work: _____ Home:_____
Mother/or Legal Guardian				Cell: _____ Work: _____ Home:_____
Adult Witness				