Greater Fayetteville Adventist Academy
2601 Lone Pine Drive
Fayetteville, NC 28306
910-484-6091
Secretary.gfaa@outlook.com

Consent to Treatment for 20 _____ - 20 _____

Medical Information

Students entering Greater Fayetteville Adventist Academy for the first time or students entering the Pre-K or Kindergarten program MUST have a physical, dated within the past year, from a physician, on file with the school. Immunization records and a copy of the student's birth certificate MUST be on file PRIOR to beginning of classes.

It is imperative that the staff of _____ be aware of any potential life-threatening illness that your child may have. Please check the following that apply to your child:

Asthma: _____ Yes _____ No (If yes, we must have an inhaler in the office for your child)
Diabetes: _____ Yes _____ No _____
Allergies: _____ Yes _____ No _____
Other: _____

Current Medications: _____

Family Doctor: _____
Doctor Name

_____
Address City ST ZIP

_____
Phone Number

Preferred Hospital: _____

Insurance: _____ Policy No._____ Group No._____

Policy Holder: _____

I, the undersigned parent or legal guardian of _____, a
(Student Name)
minor, do hereby consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital services that may be rendered to said minor under the general or special supervision of any physician and surgeon, licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, where such diagnosis or treatment is rendered at the office of said physician or at the licensed hospital. It is understood that reasonable effort will be made to contact the doctor listed before the school or other organization calls any other physician.

It is further understood that this consent is given in advance of any specific diagnosis, treatment, or hospital care which might be required, but is given to provide authority to the school, or the physician, to exercise their best judgment as to the requirements of such diagnosis and treatment. It is further understood that reasonable effort be made to contact parents/guardians or emergency contacts prior to using this consent.

I hereby authorize any hospital or physician, which has provided treatment to the above named minor to surrender physician custody of such minor to the above agent upon completion of treatment.

This consent shall remain in continuous effect until revoked in writing and delivered to the above named school or organization entrusted with the custody of said minor.

I hereby authorize any hospital, physician, or other person who has attended or examined the minor to furnish to the General Conference Insurance Service, 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 photo copy of this authorization shall be considered as effective and valid as the original. ***I am responsible for any fees incurred not covered by insurance.***

_____ _____
Parent Signature Date