

Monte Vista Christian School
Consent for Treatment of Student Authorization

Student Name (Printed): _____ Date of Birth: _____

In case of emergency, illness or accident to the child named above, the school is authorized to take the child to an emergency hospital or any licensed physician. It is understood that the parents will be notified as soon as possible.

I/We the undersigned parent(s) of _____, a minor and/or a student, do hereby authorize Monte Vista Christian School as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practices Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. It is understood that this authorization if given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician in the exercise of his/her best judgment may deem advisable. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California.

I/We hereby authorize and hospital, which has provided treatment to the above-named minor pursuant to the provisions of Section 25.8 of the Civil Code of California to surrender physical custody of such minor to my/our above-named agent(s) upon completion of treatment. This authorization is given pursuant to Section 12283 of the Health and Safety Code of California.

These authorizations shall remain effective for as long as the student is in residence at Monte Vista Christian School, unless sooner revoked in writing delivered to said agent(s).

I give my permission for Monte Vista Christian School to administer non-prescription medications such as analgesics, cough suppressant, antihistamine, stomach treatments (diarrhea, acid, nausea) to my student, when the need arises. This form precludes the need for further communication except in the case of an emergency.

Allergies: _____

Medical Conditions: _____

PARENT SIGNATURE _____ **DATE** _____

PRINTED PARENT NAME _____

STUDENT SIGNATURE (if over 18) _____ **Date:** _____

PLEASE SEND ALL MEDICAL AND DENTAL BILLS TO: (print legibly)

Name: _____

Address: _____

City: State, Country & Postal Code: _____

Emergency Phone # Cell: _____ home: _____

Signature: _____

(Parent/Legal Guardian)

PLEASE ATTACH A COPY OF BOTH SIDES OF YOUR INSURANCE AND PRESCRIPTION CARDS TO THIS FORM. NOTE: The school will purchase a Blue Cross policy for any international student with a MVCS issued Form I-20 upon their arrival at MVCS.