CYPRESS ADVENTIST SCHOOL
A Good Place to Grow

PARENT MEDICAL AUTHORIZATION

Student's Last Name (Please Print)	Student's First Name	Date of Birth	Grade
_____	_____	_____	_____

I/We understand that Cypress Adventist School will make immediate and every effort to contact me in each and every situation where/when there is any concern or question about my child's health or well-being.

As the parent(s)/guardian(s) of the student, a minor, I/we do hereby authorize a Cypress Adventist School staff member(s) to act as my/our agent(s), to consent to x-ray, anesthetic, medical or surgical diagnosis or treatment as/or hospital serviced that may be rendered under the general or special supervision of any licensed physician/surgeon, whether such a diagnosis or treatment is rendered at the office of said physician or at a licensed hospital.

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 Cypress Adventist School or the physician to exercise their best judgement as to the requirements of such diagnosis or treatment.

I/We hereby authorize any hospital which has provided treatment to the above-named minor to surrender physical custody of such minor to the agent(s) upon completion of treatment.

I/We hereby authorize any hospital, physician or other person who has attended or examined the minor to furnish to General Conference Insurance Service, or its representative, any and all information with request 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/We have read and understand the extent of this authorization and that it shall remain effective until the end of the current school year.

This document is a sample only. All hard copies will be signed at school when you come to register your child.