Due When You Arrive For Registration

OUTDOOR SCHOOL

Student Registration & Consent to Treatment Form

Registration Fee: Includes all meals and activities. Teacher: No Charge **All Others: $50.00**

Student's Name: _____

Address: _____
City State Zip

School: _____ Teacher's Name: _____

MEDICAL

Allergies: ____ Drugs ____ Plants ____ Food ____ Bee Stings ____ Other

Please Explain: _____

Medication (please list) _____

_____

The above named student has my permission to attend the Outdoor School at Bozeman, Montana. It is understood that I will not hold the Montana Conference, the church schools, or their personnel responsible in case of accident or injury beyond that coverage provided by the student accident insurance program of the Montana Conference.

We, the undersigned parents or guardian of _____, a minor, do hereby consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered to said minor under the general or special instructions of _____, MD., or any physician the school or organization may call, whether such diagnosis or treatment is rendered at the office of said physician or at a licensed hospital. It is understood that reasonably effort will be made to contact the doctor listed above before any other physician is called by the school or other organization.

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 **the Montana Conference of Seventh-day Adventist Department of Education** or the physician to exercise the best judgment as to the requirements of such diagnosis or treatment.

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

We hereby authorize any hospital, physician, or other person who has attended or examined the minor to furnish 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 medical records. A photo copy of this authorization shall be considered as effective and valid as the original.

_____ _____
Parent Signature Date

Phone number: _____