Mercy Hospital of Williston
1301 15th Ave. W.
Williston, ND 58801

CONTINUING CONSENT TO TREATMENT

We, the undersigned, parents or legal guardian of _____ minor (s), 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 (s) under the general or special instructions of _____M.D., or his alternate, whether such diagnosis or treatment is rendered at the office of said physician, or his alternate, or at Mercy Hospital, Williston, North Dakota. We further authorize said physician, or his alternate, to exercise his discretion in authoring the disposal of any severed tissue or member.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required, but is given to encourage

Williston Public Schools Personnel

_____

(Name of person (s) into whose custody minor (s) entrusted)

and said physician, or his alternate, to exercise his best judgment as to the requirement of such diagnosis or treatment.

The consent shall be effective **for the 2002 - 2003 School Year,** unless sooner revoked in writing delivered to said physician, or his alternate, or said person(s) entrusted with the custody of said minor (s).

Name of child:_____
Age: _____Allergies:_____
Current Medications:_____
Date of last Tetanus:_____

Insurance: Name of Company _____#

Date:_____

Father:_____

Mother:_____

Legal Guardian:_____