Consent For Medical Treatment

Student's Name _____ **Social Security Number** _____
Last First Middle

Date of Birth _____ **Place of Birth** _____

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 instruction of any physician the school or organization may call, whether such diagnosis or treatment is rendered at the office of the physician or at the licensed hospital.

It is further understood that this consent is given in advance of any specific diagnosis or treatment that might be required and is given to authorize **Heritage Academy** or the physician to exercise their best judgment as to the requirements of such diagnosis or treatment.

This consent shall remain in continuous effect until revoked in writing. A copy of this authorization shall be considered as effective and valid as the original.

We hereby authorize any hospital, physician, or other person who has attended or examined the minor to furnish to any appropriate insurance company, or its representative, any and all information with respect to any illness, medical history, consultation, prescription, or treatment, and copies of all hospital or medical records.

Information about family or legal guardian(s):

Please type or print

Father's Name _____ **Mother's Name** _____
Address _____ **Address** _____
_____ _____

Social Sec. No. _____ **Home Phone** _____ **Social Sec. No.** _____ **Home Phone** _____
Work Phone _____ **Cell Phone** _____ **Work Phone** _____ **Cell Phone** _____

Employer _____ **Employer** _____
Address _____ **Address** _____
_____ _____

Insurance Company _____ **Insurance Company** _____
Policy # _____ **Group #** _____ **Policy #** _____ **Group #** _____
Address _____ **Address** _____
_____ _____

Please note that the school accident insurance is always secondary and therefore, you are encouraged to carry insurance on your child.

Emergency Contact If unable to contact parents or legal guardian:

Name _____ _____ **Phone** _____
Relationship to student

Heritage Academy *has my permission to obtain medical treatment for my child, the above named student, should an emergency arise and I cannot be reached.*

Signed _____ **Date** _____
Signature of Parent / Guardian

State of _____ **County of** _____

Sworn to and subscribed before me this _____ day of _____, 20 ____

_____ **My commission expires** _____
Notary Public