



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 _____ Relationship to student _____ Phone _____

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 _____

Notary Public My commission expires _____