# Blue Mountain Academy

## Medical Authorization & Consent Form

***For All Students***

_____ _____ _____

Student's Name Date of Birth Grade

_____

Address, City, State, Country, Zip

The parent(s)/guardian(s) of the above named student, do hereby grant emergency authorization and consent for any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital service that may be rendered to said student under the general or special instructions of any physician Blue Mountain Academy may call, whether such diagnosis or treatment is rendered at the office of the physician or at a licensed hospital.

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

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

If the insurance company does not cover services, or if I/we do not have insurance, I/we agree to take full responsibility of all financial obligations incurred during treatment and/or hospitalization of the student.

**Parent(s)/Guardian(s) are responsible for any co-payment at the time of service.**

### Student's Emergency Contact

| | |
|---|---|
| ☐ Mother ☐ Guardian _____ | ☐ Father ☐ Guardian _____ |
| Address, City _____ | Address, City _____ |
| State, Country, Zip _____ | State, Country, Zip _____ |
| Primary Phone _____ | Primary Phone _____ |
| Alternate Phone _____ | Alternate Phone _____ |

### Secondary Emergency Contact

| | |
|---|---|
| Name _____ | Name _____ |
| Relationship _____ | Relationship _____ |
| Primary Phone _____ | Primary Phone _____ |
| Alternate Phone _____ | Alternate Phone _____ |
| Address _____ | Address _____ |

| **Student's Primary Care Physician** | **Insurance Information** |
|---|---|
| Physicians Name _____ | Name of Insured _____ |
| Address, City _____ | Insured's DOB _____ |
| State, Country, Zip _____ | Insurance Company _____ |
| Telephone _____ | Employer _____ |
| Fax _____ | Policy Number _____ |

****A copy of the back and front of the insurance card must accompany this document.****

_____ _____

Signature of Parent/Guardian Date (must be reviewed & signed yearly)

| ****If changes please complete new form**** | **Date** | **Parent/Guardian Signature** |
|---|---|---|
| ☐ Reviewed/No changes | | |
| ☐ Reviewed/No changes | | |
| ☐ Reviewed/No changes | | |