Union Springs Academy

P.O. Box 524 Union Springs, NY 13160 ~ Phone: (315) 889-7314 Fax: (315) 889-7188
Website: unionspringsacademy.org

Consent for Treatment and Authorization to Release Information

We, the undersigned parents or guardians 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 the physician Union Springs Academy may call, whether such diagnosis or treatment is rendered at the office of said physician or at a licensed hospital.

It is understood that this consent is given in advance of any specific diagnosis or treatment which might be required and is given to authorize Union Springs Academy or to the physician to exercise their best judgement as to the requirements of such diagnosis or treatment.

We hereby authorize any hospital, physician, or other person who has attended or examined the minor to furnish to the insurance company retained by the school any and all information with respect to an illness, medical history, consultation, prescriptions, or treatment, and copies of all hospital or medical records. A photo copy of this authorization of this authorization shall be considered effective and valid as the original.

Date of last Tetanus Booster_______________ List All Allergies and Allergy Medications: ________________

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Name of Primary Care Physician: ____

Name of Physician's Office/Practice**:** _____________________________ Office Phone___________________

Address for Primary Care Physician's Office: ____

Student's Insurance Information:

Subscriber's Name _______________________________________ Date of Birth________________________

Company ____ ***Please attach a front and back**

Policy # ____ **copy of your insurance card to this form.**

Group ID #: ______________________Insurance Company Phone __________________________________

Consent to Treatment and Authorization to Release Information

Family Information:

Father's Name_____________________________ Mother's Name ______________________________________

Father's Social Security # _______-_______-_______ Mother's Social Security # ________-_______-______

Father's Employer _______________________________ Mother's Employer_____________________________

Father's Cell Phone (________)_________-__________ Mother's Cell Phone (________)_______-_______

Father's Work Phone (______)_________-__________ Mother's Work Phone (_______)________-________

Student's Social Security # _________-______-________ Student Date of Birth __________________________

Father's Signature____Date________________________

Mother's Signature____Date________________________

Guardian's Signature____Date_______________________

Name & Phone of Emergency Contact if parent can't be reached _______________________________________

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<u>Secondary Student Accident Insurance</u>

A secondary student accident insurance policy is provided for all students who have completed registration. The student should promptly report any injury to their dean on duty within 24 hours.