Student's Name_____ Grade _____ Year_____

WISCONSIN ACADEMY

CONSENT FOR MEDICAL TREATMENT

_____ _____ _____
Student Name (Please Print) Date of Birth Social Security #

In the event your child should suddenly become ill or injured while at school, prompt medical attention may be required. Delaying treatment while trying to contact parents could be serious. Therefore, we are asking you to pre-authorize appropriate medical/dental/vision/health treatment should the need occur. Please carefully read and complete this form. There are three (3) main situations where a student might need medical treatment at the local medical center, urgent care, or emergency room. These situations include, but are not limited to, the following:

1. When a student develops an acute medical problem, i.e. sore throat, flu, sinus infection, or other medical condition where the attention of a healthcare provider is needed.
2. When a student develops an acute dental or vision problem that may require prompt attention.
3. In the event your student should suddenly become ill or injured while at school and prompt medical attention is required.

I, the undersigned parent or legal guardian of the above-named minor, do hereby consent to any X-ray examination, immunization, dental or vision treatment(s), anesthetic, medical or surgical diagnosis or treatment, hospital service, mental or behavioral health treatment, or services that may be required to aid the minor under the general or specific instruction of a physician. I consent to the administration of over-the-counter medications and/or prescription medications ordered by a physician.

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 the school employee of Wisconsin Academy, or the treating physician, to exercise their best judgment as to the requirements of such diagnosis or treatment.

A copy of this authorization shall be considered as effective and valid as the original. This consent shall remain in effect for the current school year unless revoked in writing.

Date _____

_____ _____ _____
Father's Signature Mother's Signature Legal Guardian's Signature

_____ _____ _____
Print Name Print Name Print Name

Cell (_____) _____-_____ Cell (_____) _____-_____ Cell (_____) _____-_____

Home (_____) _____-_____ Home (_____) _____-_____ Home (_____) _____-_____

Work (_____) _____-_____ Work (_____) _____-_____ Work (_____) _____-_____

Alternate Emergency Contact _____ Cell (_____) _____-_____

Relationship to Student _____ Home (_____) _____-_____

RESPONSIBLE PARTY BILLING INFORMATION

Name of insurance holder or responsible party_____

Address _____City _____ State _____ Zip Code _____

Cell (____) _____-_____ Home (_____) _____-_____ Work (_____) _____-_____

Email _____ Birthdate of Responsible Party _____

Copy of Insurance Card is on File: Yes _____ No _____

Comments: _____

_____

MEDICAL ALERTS

Known Allergies: _____

_____

_____

Current Prescription Medications: _____

_____

_____

History of Major Surgeries: _____

_____

_____