



Mt. Olivet Junior Academy

## Consent to Treatment and Health Insurance Information

We, the undersigned parents or guardians of \_\_\_\_\_, a minor, do hereby consent and authorize Mt. Olivet Jr. Academy and its representatives to secure any x-ray examination, medical or surgical diagnosis or treatment, and hospital service that may be required by said minor in the event of an accident or injury. The school may call any physician and such diagnosis or treatment may be rendered at the office of said physician, at a licensed hospital, or any other place. I, the undersigned, agree to pay the cost of such care and to hold Mt. Olivet Jr. Academy harmless for all expense of such services or for any other liability in the procuring such service. The undersigned specifically requests that if possible, the following physician be called for the purpose of rendering such treatment:

Physician's Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

It is further understood that this consent is given in advance of any specific diagnosis, treatment or need which might be required and given to authorize Mt. Olivet Jr. Academy or the physician to exercise their best judgment.

The above student is \_\_\_\_\_ is not \_\_\_\_\_ covered by health insurance in addition to school coverage.

Present Health Insurance Company: \_\_\_\_\_ Dated: \_\_\_\_\_

Coverage by: \_\_\_\_\_ Relationship: \_\_\_\_\_

1. In the event that your child becomes ill or injured, it may be necessary to notify you by phone. Please list a phone number by which you can be reached during the regular school hours: \_\_\_\_\_.
2. If it is necessary to take your child to a hospital or physician's office, does the physician have your permission to use:  
a. Oral or Injectable Antibiotics?  Yes  No b. Tetanus Medication?  Yes  No
3. Please list any pertinent medical conditions that your child may have (diabetes, allergies, asthma, etc.)  
\_\_\_\_\_.
4. Please list all medications your child is now taking on a daily basis.  
\_\_\_\_\_.
5. Please list all medications or food allergies:  
\_\_\_\_\_.

Please list any medication necessary for the school to administer to your child. A written doctor's order must accompany the medication indicating when and how often the medication is to be given, as well as the method by which it is to be given. This information must be on written on the label.  
\_\_\_\_\_

The school cannot administer any prescription medications to a student without the written instructions from a doctor and a signed Medication Form from parents in the office. Non-prescription medications must be self-administered by students; however, there are other policies regarding their use (see student handbook).

I understand the requirements and regulations of the school, and pledge my full cooperation.

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date