# ASMSA PERMISSION TO TREAT FORM

## STUDENT INFORMATION

Name: ______________________________ D.O.B.: __________ SSN: __________________ Gender: M F

Address: ___________________________________ City: ____________________ State: _____ Zip: _________

## THIS SECTION TO BE COMPLETED BY PARENT/GUARDIAN

Parent/Guardian Name(s): ______________________________________________________________________

Address: ___________________________________ City: ____________________ State: _____ Zip: _________

Home Phone: ___________________________________ Work Phone: __________________________________

Emergency Contact: ______________________________________ Phone Number: _______________________

## INSURANCE PROVIDER INFORMATION (Or, attach copy of insurance card)

Health Insurance Company: _________________________________________ Policy #: ____________________

Insurance Company Address: ___________________________________ Phone Number: __________________

Name of Policy Holder: ________________________________________ Policy Holder's D.O.B.: ______________

Policy Holder's Occupation/Employer: ______________________________________________________________

Employer's Address: ______________________________ City: ________________ State: _____ Zip: _________

HMO Information (if applicable): ________________________________________________________________

Pre-Treatment Authorization Plan Number (if applicable): ______________________________________________

## STUDENT MEDICAL INFORMATION

- Does the student have any allergies? If yes, please specify: __________________________________________

- List any medication the student takes regularly. Failure to turn prescription and unapproved over the counter medication in to the Nurse is a violation of school policy. Additional medications may be listed on the back.

Medication: ___________________________________ Strength: _______________ Dosage: _______________

Medication: ___________________________________ Strength: _______________ Dosage: _______________

Medication: ___________________________________ Strength: _______________ Dosage: _______________

- List any other conditions that may require special care or diet, as well as any important/recent hospitalizations

(ie, diabetes, asthma, etc): ______________________________________________________________________

_____________________________________________________________________________________________

This form is used to assist ASMSA personnel in ensuring your student receives medical care or attention, including in case of emergency. This information will be used only by ASMSA personnel and by appropriate health care personnel. No information on this form will be released to any other party without written consent.

I hereby authorize any medical treatment for my student which may be advised or recommended by ASMSA personnel and/or medical personnel in area hospitals. I agree to be responsible for all financial charges incurred as a result of ancillary services (ie, X-rays, etc.) and other services not covered by insurance.

Student's Parent/Guardian Name (please print): ______________________________________________________

Student's Parent/Guardian Signature: _____________________________________________ Date: __________