



# ST. JOHNSBURY ACADEMY

St. Johnsbury Vermont, 05819 | Phone: (802) 748-8171 | Fax: (802) 748-5463 | [www.stjohnsburyacademy.org](http://www.stjohnsburyacademy.org)

Student Name \_\_\_\_\_

## Permission for Medical Treatment/Release of Medical Information

In rare instances, a surgical emergency arises in which written consent by the parent or guardian is legally required but the proper person cannot be located. In this event, and in order to avoid delay which might jeopardize the life or recovery of a student, we request the following information from the parents or guardian, with the understanding that every effort will be made to contact them in an emergency. **This form MUST be completed every school year.**

Student's Social Security Number: \_\_\_\_\_

**Please check boxes signifying acceptance.**

- I authorize the School Nurse, or other health care providers considered appropriate by them, to carry out accepted procedures for diagnosis, immunization, medical and minor surgical treatment, or counseling for my (son, daughter, ward). I authorize the School Nurse or other physicians or surgeons considered appropriate by her to give necessary anesthesia and perform emergency surgical operations on my (son, daughter, ward).
- I agree to notify St. Johnsbury Academy of any conditions arising when my (son, daughter, ward) is not at school.
- I hereby authorize St. Johnsbury Academy to release information concerning my child to appropriate health care providers.
- I authorize health care providers to release information to the school.
- I hereby authorize payment directly to the health care provider of the hospital insurance benefits otherwise payable to me but not to exceed the balance due of the hospital's regular charges for this period of hospitalization. I understand I am financially responsible to the health care provider for charges not covered by this authorization and any applicable rates and terms.
- Our health care professionals, counselors, advisors, and administrators strive to respect the privacy of our students; however, there are times when information may need to be shared with parents, select faculty, and school officials. Therefore, parents and students consent, as a condition of enrollment, that otherwise confidential health care and counseling information may be disclosed on a need to know basis to the extent necessary to protect the health, safety, and welfare of the student and community.

X \_\_\_\_\_  
PARENT/GUARDIAN SIGNATURE

\_\_\_\_\_  
DATE

# Health Insurance Information (every student MUST HAVE health insurance)

\_\_\_\_\_  
POLICY HOLDER'S NAME

\_\_\_\_\_  
POLICY NUMBER

\_\_\_\_\_  
SOCIAL SECURITY NUMBER

\_\_\_\_\_  
GROUP NUMBER

\_\_\_\_\_  
RELATIONSHIP TO POLICY SUBSCRIBER

\_\_\_\_\_  
INSURANCE COMPANY NAME

\_\_\_\_\_  
**WHERE TO SEND CLAIM FORMS** MAILING ADDRESS: STREET

\_\_\_\_\_  
STREET LINE 2

\_\_\_\_\_  
CITY STATE COUNTRY ZIP CODE

( )

\_\_\_\_\_  
TELEPHONE NUMBER WITH AREA CODE

## Person Responsible for Health Care Bills

\_\_\_\_\_  
LAST NAME

\_\_\_\_\_  
FIRST NAME

( )

\_\_\_\_\_  
HOME PHONE WITH AREA CODE

( )

\_\_\_\_\_  
BUSINESS PHONE WITH AREA CODE

( )

\_\_\_\_\_  
FAX NUMBER WITH AREA CODE

\_\_\_\_\_  
E-MAIL ADDRESS

\_\_\_\_\_  
MAILING ADDRESS: STREET

\_\_\_\_\_  
STREET LINE 2

\_\_\_\_\_  
CITY STATE COUNTRY ZIP CODE

**Please include a copy of BOTH sides of your insurance card and prescription drug card.**