CONSENT FOR MEDICAL TREATMENT
UPPER COLUMBIA ACADEMY

SECTION A: Student Information

Student Name _____ _____ _____ _____ _____
Last First Middle Gender Grade Birth Date Social Security #

Allergies (medications, food, bee stings, etc.) _____

Current medical concerns _____

Medication taken currently _____

Serious illnesses, operations, & other significant health history _____

_____

SECTION B: Parent/Guardian Information

Father_____ **Mother**_____

Occupation _____ **Occupation** _____

_____ _____
Home Address **Home Address**

_____ _____
City State/Province Zip **City State/Province Zip**

(___)_____ (___)_____ (___)_____ (___)_____
Home Phone **Work Phone** **Home Phone** **Work Phone**

(___)_____ (___)_____ (___)_____ (___)_____
Cell Phone **Fax** **Cell Phone** **Fax**

Emergency contacts other than Parent/Guardian _____ (____)_____

_____ (____)_____

Person(s) legally responsible for student_____

Contact person(s) for medical needs _____

Person(s) financially responsible for students medical_____

Medical Insurance Company_____

Policy Holder _____ Employer_____

Birth date of Policy Holder _____ SS# of Policy Holder _____

Group # _____ Policy # _____

Is this a Preferred Provider Plan?_____ Does this plan require a referral from a Primary Care Physician?_____

P.C.P. or Family Physician_____ (___)_____ (___)_____
Name Phone Fax

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD. **FORM CONTINUED ON BACK**

_____ **Name of Student**

SECTION C: Consent (PLEASE INITIAL ALL THAT APPLY)

_____ Student is 18 or older and does not need parental consent for treatment or medication.

_____ I, the undersigned parent or guardian of the above named student, a minor, do hereby consent to any x-ray examination, immunization, anesthetic, medical or surgical diagnosis, treatment and/or hospital service that may be rendered to said minor under the general or specific instructions of a physician. It is understood that reasonable effort will be made by the attending physician to contact me so that the treatment necessary for the best interest of the above named student may be given.

It is further understood that this consent is given in advance of any specific diagnosis or treatment that may be required and is given to authorize Upper Columbia Academy or the physician to exercise their best judgment as to the requirements of such diagnosis or treatment.

This consent shall remain in continuous effect until revoked in writing and delivered to Upper Columbia Academy.

I hereby authorize any hospital, physician or other person who has attended the minor to furnish the insurance service, or its representative, any and all information with respect to any illness, medical history, consultation, prescriptions, or treatment and copies of all hospital or medical records. A photo copy of this authorization shall be considered as effective and valid as the original. I understand that I am responsible for costs associated with the medical care provided.

_____ I authorize mental health professionals to release to Upper Columbia Academy any mental health/psychiatric and/or drug and alcohol assessment information that may pertain to the safety of the student or the school.

I grant permission and authorize school personnel to administer the following medications or generic equivalents to my minor child as ordered in writing by the school physician or as prescribed by another physician. (Please initial all that apply.)

_____ Tylenol	_____ Sore throat lozenges	_____ Benadryl	_____ Immodium	_____ Vitamin C
_____ Advil	_____ Robitussin DM	_____ Claritin	_____ Phenergan	_____ Charcoal capsules/tablets
_____ Aleve	_____ NyQuil/DayQuil	_____ Tums	_____ Visine eye drops	_____ Other (list) _____
_____ Sudafed	_____ Cough drops	_____ Pepto Bismol	_____ Dramamine	_____ Other (list) _____

I request permission for and authorize my child to have and to self-administer the following medications while enrolled as a student at UCA. I have reviewed the medication administration procedure with my child and I believe that he/she is capable of self-administration of the medication and of monitoring himself/herself for side effects. I understand that all medications must be maintained in the original container with the original label. School personnel may examine the medication. Any medication that is misused or is not in the original container may be confiscated by school personnel.

_____ _____ _____ _____

In consideration of this authorization the undersigned agrees to indemnify, defend, and hold harmless Upper Columbia Academy, its affiliated entities, including the Upper Columbia Conference of Seventh-day Adventists and Upper Columbia Corporation of Seventh-day Adventists and the Academy Operating Board, the individual members thereof and any officials or employees of the school and the Academy Operating Board from any claims or liability for injury or damages including but not limited to costs and reasonable attorney's fees, caused or claimed to be caused from the administration of these medications.

Parent/Guardian Signature _____ **Date** _____

I understand that I may only have medications in my dormitory room and/or backpack that are listed above and that these medications are for my use and not to be shared with other students. I give my permission for UCA staff to discuss any medical conditions and/or medical needs that I have with my parents/guardians and with medical providers who care for me.

Student Signature _____ **Date** _____