

Mount Vernon Academy

P.O. Box 311 - 525 Wooster Rd.

Mt. Vernon, OH 43050

Phone (740) 397-5411 ~ Fax (740) 397-3901

HEALTH REPORT FORM**Please note: Photocopies will be made. Please PRINT using black or dark blue ink (NO pencil please).**

Student Name _____ Social Security # _____
 Address _____ City _____ State _____ Zip _____
 Home Phone (____) _____ Date of Birth _____
 Parent/Guardian Legal Name _____ Social Security # _____
 Employer _____ Work Phone # _____
 Insurance Company _____ Policy Number _____

**CONTINUING CONSENT TO MEDICAL TREATMENT
 AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

We, the undersigned parents or legal guardians of _____ (student's name), a minor, do hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital service which may be rendered to said minor under the general or special instructions of _____ (family physician) or any physician the school may call, whether such diagnosis or treatment is rendered at the office of said physician or at a licensed hospital. It is understood that reasonable effort will be made to contact the physician listed above and/or the parent or guardian before any other physician is called by the school.

It is further understood that this consent is given in advance of any specific diagnosis or treatment which might be required and is given to authorize Mount Vernon Academy or the physician to exercise their best judgment as to requirements of the diagnosis or treatment.

This consent shall remain in continuous effect for the duration of this student's enrollment at Mount Vernon Academy unless revoked in writing and delivered to the Mount Vernon Academy Health Office.

We hereby authorize any hospital, physician, or other medical personnel who has attended or examined the minor to furnish our insurance company, _____ (name of company), 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 Xeroxed copy of this authorization shall be considered as effective and valid as the original.

INFORMATION WHICH MAY BE IMPORTANT IN AN EMERGENCY

1. Medications which the student takes regularly _____
2. Allergic reactions to medications, foods, or contact with natural or artificial matter _____
3. Medical conditions such as diabetes, convulsions, asthma, etc., about which the attending physician should know in advance of diagnosis or treatment _____

REQUIRED SIGNATURES

Signature of Father/Legal Guardian _____ Date _____
 Signature of Mother/Legal Guardian _____ Date _____
 Home Phone of Parent/Legal Guardian _____ Work Phone _____ Cell Phone _____
 Name of Family Physician _____ Physician's Phone _____
 Name of Emergency Contact in case the above cannot be reached _____
 Phone Number of Emergency Contact _____ Relationship to student _____