Verification of Medical Insurance-
Battle Mountain High School

STUDENT'S NAME_______________________________ Grade_________________

_______________________________________ ________________________
Insurance Company Policy Number

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Purpose: Provide means for procuring an authorized signature for medical treatment of minors when the parents (or legal guardians) are not available of cannot be contacted to sign. The authorization must be signed by both parents (or legal guardians) and witnessed.

AUTHORIZATION TO CONSENT TO TREATMENT OF MINOR

(I), (We), the undersigned parent(s) of the ________________________________, a minor child, do hereby authorize Lander County School District as agent(s) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered under the general or special supervision of the AVAILABLE, M.D., whether such diagnosis or treatment is rendered at the office of said physician or in a licensed hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of out aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable.

The authorization shall remain effective as long as child is enrolled at BMHS unless sooner revoked in writing delivered to said agent(s) or said physician.

Additional medical information you feel we should know:

Medicine: ____

Allergies: ____

___________________________________ ______________________________
Witness Date

___________________________________ ______________________________
Witness Father's Signature

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Mother's Signature

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Legal Guardian's Signature