CAMPION ACADEMY

CONSENT TO TREATMENT AUTHORIZATION School Year 2023-2024

To be signed by parent or guardian

INFORMATION:

First Name _____ Middle Name_____ Last Name_____ Grade_____
Address_____
City _____State _____ Zip _____ Date of Birth _____
Student Phone # _____ Student's Mother's First Name _____
Work Numbers: Mother (____) _____Father (____) _____
Cell Phone #'s: Mother (____) _____Father (____) _____

Medical Information:

Date of last Tetanus shot _____
Allergies to Medications _____
Chronic Medical Problems _____
Current Medications _____

Insurance Information: ☐ NONE or ☐ The Insurance Company which covers the above-named child is:

Name of Company _____ Policy Number _____ Group Number _____
Address _____ City _____ State _____ Zip _____
Name of Insured _____ Date of Birth _____
Relationship to Child_____ Social Security #_____

Name of an Adult relative or friend to be notified in case of emergency:

Name _____ Phone (____)_____
Address _____ City _____ State _____ Zip_____

AUTHORIZATION:

I hereby authorize and give my consent to the staff of Campion Academy, who are designated, to sign medical forms giving medical professionals permission to perform upon or administer to my student listed above any medical or surgical treatment or diagnosis, including substance screening and Covid testing when necessary. I also give my permission to administer whatever anesthetic may be necessary or advisable during medical or surgical procedures.

I further consent to transportation of the above-named child to the nearest or most appropriate medical facility. This authorization is intended to cover emergency measures, x-ray exams, immunizations, infections, and minor operations and procedures, and in the event of an indicated major operation, the Academy authorities will attempt to contact me by phone before relying upon this authorization. It is intended that no medical or surgical treatment will be rendered the student without his/her personal consent, except in emergency situations (i.e. unconsciousness).

I give my permission for Campion Academy staff to give prescription medication as prescribed by the person with prescriptive authority. I will specify on the over-the-counter form which medications my student may take and have someone with prescriptive authority sign it as well as myself. I understand that if the over-the-counter form is not signed my student cannot receive any over-the-counter medications.

FINANCIAL TERMS:

I understand that the Student Accident Insurance provided through Campion Academy is "EXCESS ONLY" coverage, which means that my insurance, if any, is primary insurance for all treatments and claims. The Student Accident Insurance will only pay benefits for actual expenses incurred for any covered loss sustained by the insured by reason of injury in cases where the student is not covered by other insurance, or for that portion of actual expenses incurred which is in excess of all other compensation paid or payable to the insured, or on the insured's behalf by or under another Health Care Plan. (See the "Christian Educators Insurance Trust" flyer for more detail and Scope of Coverage). I accept full responsibility for payment of medical expenses incurred by my student while under Campion Academy's care. In cases where other insurance benefits may apply, I will promptly forward copies of the "Explanation of Benefits" (EOB) page to Campion Academy, detailing what benefits, if any, were paid by other Health Care Plans. I understand that Campion Academy can not pursue benefits under the "Student Accident Insurance" without the EOB, if any, attached to the claim. I understand that I am financially responsible for charges not covered by any insurance payments.

Parent/Guardian Signature _____**Relationship to Student** _____

Print Name _____ **Date** _____