DAA
Dakota Adventist Academy

Consent to Treatment Authorization

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 (_____) _____ Work Numbers: Father (_____) _____

Cell Phone #: Mother (_____) _____ Cell Phone #: Father (_____) _____

Medical Information:

Date of Last Tetanus shot ___/___/___

Allergies to Medications _____

Chronic Medical Problems _____

Current Medications _____

Insurance Information: ☐ None ☐ 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 Dakota Adventist Academy who are designated, to sign medical forms giving the hospital, physician, or dentists permission to perform upon or administer to my student listed above any medical or surgical treatment or diagnosis, including substance screening when necessary. I also give my permission to administer whatever anesthetic may be neces sary 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 autho rization. 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).

_____Initial Here

I give my permission for Dakota Adventist 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 cannon receive any over-the-counter medications.

Financial Terms

I understand that the Student Accident Insurance provided through Dakota Adventist 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 Dakota Adventist Academy's care. In cases where other insurance benefits may apply, I will promptly forward copies of the "Explanation of Benefits" (EOB) page to Dakota Adventist Academy cannot 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 ___/___/___