Student Healthcare Authorization

**** ATTENTION PARENTS ****

PLEASE PHOTOCOPY THE **FRONT AND BACK** OF YOUR MEDICAL INSURANCE IDENTIFICATION CARD AND AFFIX BOTH COPIES WITHIN THIS BOXED AREA.

PLEASE HAVE THE ENROLLED MEMBER ON THE HEALTH PLAN SIGN BOTH PHOTOCOPIES TO VERIFY THE ACCURACY OF THE INFORMATION PROVIDED.

Form Courtesy of Joseph V. De Santi, M.D.

The above health insurance information is for my daughter/son ________________________.
NAME OF STUDENT

Mr./Mrs. ____ is/are hereby granted
NAME(S) OF TEACHER(S)/CHAPARONE(S)

permission to act on my/our behalf to ensure our daughter/son receives timely and appropriate medical care in the event of an illness or injury. Should a medical facility or treating provider have questions pertaining to this authorization, I/we may be contacted at the following telephone number(s) listed below. This authorization expires on ______________________.

_________________________________ Parent/Guardian Signature

_________________________________ Parent/Guardian Signature

Cell: ____________________________

Work/Home: _______________________

Cell: ____________________________

Work/Home: _______________________

The information contained in this document is protected under HIPAA and the Privacy Act of 1974. Unauthorized release of this information may be unlawful and subject to civil and criminal penalties. Document is to be destroyed when information is no longer authorized to be shared beyond the expiration date shown above. Authorization is restricted to this original "ink" document only and is non-transferable to a copy or facsimile. Any alterations to this document will void this authorization.