MEDICAL TREATMENT AUTHORIZATION

CADET'S HEALTH INSURANCE

This form must be completed by the Cadet's Parent(s) and submitted to the Infirmary before the cadet may reside in on campus or participate in Academy programs. Information will be kept confidential. Full disclosure of the cadet's medical history and needs is essential to the cadet's proper are and well-being.

Cadet's Name: _____ Birth date: ____/____ /_____
Last name First Middle (initial)

Allergies(list all): _____

Type of Reaction:_____

Primary Parent/Guardian Contact Information

Name:_____Relation:_____

Home Phone Number:_____
Cell Phone Number:_____
Work Phone Number:_____

Email:_____
Mailing Address:_____
_____

Secondary/Emergency Contact Information

Name:_____Relation:_____

Home Phone Number:_____
Cell Phone Number:_____
Work Phone Number:_____

Email:_____
Mailing Address:_____
_____

HEALTH INSURANCE – Please include with this form a copy **(front and back) of the cadet's insurance card** and any **prescription cards**. Changes in coverage should be faxed/mailed to the Infirmary as soon as possible.

Insurance Co.: _____ Policy Holder: _____

Policy Holder's SSN: _____ Policy Holder's Birth date: _____

CREDIT CARD TO BE USED FOR MEDICAL EXPENSES

Circle One: Visa Mastercard	Card Number:	
	Expiration Date:	Security Code:

Medical Treatment Authorization – By signing below, the cadet's parent/guardian authorizes any hospital, physician, or medical care provider to render appropriate medical care to the cadet named above. This authorization is for medical care that is usual and customary for treatment on an outpatient basis, including but not limited to x-rays, blood work, urinalysis, and the administration of appropriate medications.

Parents' Statement Authorizing Medical Treatment:

- ✓ If I cannot be reached immediately during a medical emergency involving my son/daughter (cadet), I consent for MMA to act in loco parentis, and I consent for MMA to grant permission for emergency treatment for my cadet, including surgery requiring an anesthetic.
- ✓ I authorize MMA's Infirmary staff to exchange medical information with care providers as necessary to ensure provision of appropriate medical care to my cadet.
- ✓ I authorize any hospital or physician rendering medical care to my cadet to provide copies of medical records and to share clinical information with MMA's Infirmary staff.
- ✓ I authorize MMA Infirmary staff to inform Academy faculty and staff members about my cadet's medical conditions or treatments that may bear on his/her participation and performance in Academy programs.

_____ _____

Parent/Guardian Signature Date