PERMISSION FOR TREATMENT

I. Medical Treatment/Medication:
Permission is hereby granted to attending medical personnel to dispense medication and provide needed medical or surgical treatment, x-ray examinations, and immunizations for:

Student Name_________________________________________________________

In the event of serious illness or injury, or the need for major surgery, I understand that an attempt will be made by a physician or the College to contact the parent, guardian or other designated contact. If said physician or College is unable to communicate with them, the necessary treatment for the above student may be given. (A parent or guardian MUST sign if student is under 18 in order for medical treatment to be given. If statement is not signed, the hospital/doctor MUST first get permission from the parent/guardian before medical treatment can be given.)

_______________________________________________                     /                    /
Signature of Student                                     Date

_______________________________________________                     /                    /
Signature of Parent/Guardian                          Date

CONFIDENTIALITY STATEMENT: This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

At the Beloit College Health Center your personal health information is kept confidential. You must give written permission for it to be shared with any medical provider outside of the Health Center or the Beloit Physician Hospital Organization. The BPHO provides campus physician services and our laboratory and x-ray services.

You will need to sign a release of medical information if your records or personal health identification are to be shared outside of the providers as stated above.

When you use the services of the above you will be asked to sign a release for billing purposes.

A log will be placed inside your chart for you to review that will state when and with whom your PHI was shared and an area that indicates whether your signature was necessary.

Your health center file will be marked with a red confidential sticker.

You will be asked to read the preceding statement and sign that you have read the information. This will also be placed in your chart.

I, ____________________________________, have read and understand the above statement.

Signature __________________________________   Date _________________________________

INTERCOLLEGIATE ATHLETES: If I choose to participate in Varsity/Intercollegiate Athletics, I understand that a copy of the Health History and Physician Record will be forwarded to the Athletic Trainer. Signature: ____________________________ Date: _____________

INSURANCE COVERAGE INFORMATION

Primary Policy Holder:_____________________________________________________

Insurance Type: (circle one)          HMO          90-day          College Student Plan          Other □          None □

My insurance plan allows for my student to be treated in the Beloit community:  Yes □          No □

Restrictions:______________________________________________________________

Insurance Company Name: ________________________        Insurance Phone Number:________________________

Address: Number & Street        City        State        Zip

Student Policy Number:__________________________        I.D.# ______________________

Other Coverage or Info:____________________________________________________

Policy Belongs to: (circle one)          Parent/guardian          Student

Policy covers athletic injuries that may result from participation in varsity intercollegiate athletics: (circle one)          Yes □          No □

Student Signature ____________________________ Date _____________/

If the insurance is through a parent(s), then a parent(s) signature is required.

Parent Signature ____________________________ Date _____________/