WILBRAHAM & MONSON ACADEMY 2020-2021
423 Main Street Wilbraham, Massachusetts 01095 Phone 413.596.6811 Fax 413.596.3655 website: www.wma.us

MEDICAL AUTHORIZATION FORM

Check all that apply: ☐ New Student ☐ Returning Student ☐ Day Student ☐ Residential Student ☐ Male ☐ Female ☐ Non-Binary

Student's name: _____ Date of Birth(mm/dd/yy): _____

List of known allergies: _____

Chronic Illnesses: _____

Home Address: _____

City: State, Zip: Country:

Student lives with: ☐ Both parents ☐ Father ☐ Mother ☐ Other: _____

Father's name: Email:

Address:

Father's Cell Phone: Home Phone:

Mother's name: Email:

Address:

Mother's Cell Phone: Home Phone:

Other Emergency Contact Person: Phone:

International Student
Guardian's name: Phone: _____

HEALTH INSURANCE IS REQUIRED (Health Insurance must have a U.S. address and phone number where claims can be submitted)

HEALTH INSURANCE CO: _____

Policy#_____ ID# _____ Group#_____

Ins. Co. Address_____

Ins. Co. Phone: _____

Subscriber's Name: _____ Date of Birth _____

Subscriber's Employer: _____

PERMISSION TO SUBMIT INSURANCE: I hereby authorize Wilbraham & Monson Academy Health Services and any hospital, physician or other person who has attended to or examined the above named student to furnish to the insurance company or its representative upon request any and all information (including medical records) with respect to any illness, medical history, consultation, prescription, treatment, or hospitalization. I understand that I am financially responsible for charges not covered by insurance.

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____

MEDICAL AUTHORIZATION: The undersigned hereby authorizes and grants Wilbraham & Monson Academy Health Services and/or a designated adult representative permission to administer care and treatment to the above named student. Treatment may include the routine care of injuries and illnesses; the administration of immunizations to meet the requirements of Massachusetts State Law; administration of over the counter and prescribed medication. If the student requires non-emergent treatment and care for illness/injury/health maintenance/rehabilitation/dental/mental health therapy, I grant permission for such care/treatment to be rendered. Additionally, if the student needs to be seen by a physician or medical facility in the event of an emergency, Health Services and/or a designated adult representative may make initial medical decisions on my behalf until a parent, guardian, or other emergency contact person can be reached. Health Services and/or a designated adult representative may authorize the physician in charge of my child's care to administer anesthesia and to perform such procedures/operations as may be deemed necessary in the diagnosis and treatment of him/her in case of an emergency ONLY if a parent, guardian or other emergency contact cannot be reached.

PARENT/GUARDIAN SIGNATURE: _____DATE: _____

A copy of this authorization shall be considered as effective and valid as the original.