



**Breakthrough Saint Paul
Authorization to Consent Treatment of a Minor and Emergency Information Form**

STUDENT/FAMILY INFORMATION

Please print clearly and complete all sections on both sides of this form.

Student Name	Date of Birth
Student Address	Phone

Mother/Guardian Name	Home Phone
Mother/Guardian Address	Work/Cell Phone
Father/Guardian Name	Home Phone
Father Guardian Address	Work/Cell Phone

EMERGENCY INFORMATION

Please list two persons who may be contacted in case of emergency who can provide temporary care for your child if you can not be reached.

Emergency Contact	Relationship	Phone
Emergency Contact	Relationship	Phone

PHYSICIAN/INSURANCE INFORMATION

Please provide your student's insurance information and the name and phone of your student's primary care physician.

Physician Name	Phone
Insurance Carrier	Policy Number

STUDENT MEDICAL INFORMATION

Please list all allergies, medical or mental health conditions that your student has and all medications that the student is taking. Students needing to receive medication (including over the counter and prescription drugs) while at BSP MUST HAVE a *Request to Administer Medicine at School* form with physician signature on file at BSP.

Student's Allergies _____

Medical or Mental Health Conditions _____

Medication Student is Taking _____

AUTHORIZATION TO CONSENT TREATMENT OF A MINOR

I the undersigned parent or guardian of _____, a minor, do hereby authorize Breakthrough Saint Paul and Mounds Park Academy to obtain medical care in case of emergency or serious illness. As agent for the undersigned I hereby consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment, or hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician or surgeon licensed under the provisions of the Medical Practice Act or the medical staff of any licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power on the part of our aforesaid agent to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician in the exercise of his or her best judgment may deem advisable.

In case of emergency or serious illness I understand that Breakthrough Saint Paul and Mounds Park Academy will contact me as soon as possible. If I can not be reached I hereby authorize Breakthrough Saint Paul to contact one of the Emergency Contact person(s) listed above.

This authorization shall remain effective until the end of my child's involvement with Breakthrough Saint Paul.

Parent/Guardian Name _____ Signature _____ Date _____

PERMISSION FOR NON-PARENTAL PICK-UP

I give permission for the following individuals to pick-up my child from Breakthrough Saint Paul. I understand that I must notify Breakthrough Saint Paul, in writing or by calling, whenever my child will be picked up from the program. Breakthrough Saint Paul will not release children to individuals not listed on this form without parental consent. Individuals listed on this form will be required to show identification.

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

Parent/Guardian Name _____ Signature _____ Date _____