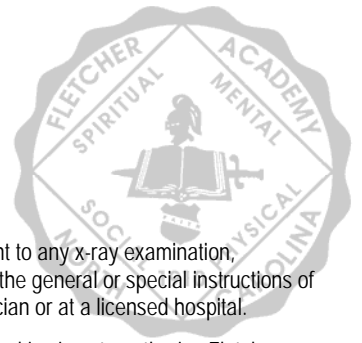


Consent to Treatment and Authorization to Release Information

Fletcher Academy



We, the undersigned parents or guardians of _____, a minor, do hereby consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital service that may be rendered to said minor under the general or special instructions of the physician Fletcher Academy may call, whether such diagnosis or treatment is rendered at the office of said physician or at a licensed hospital.

It is understood that this consent is given in advance of any specific diagnosis or treatment which might be required and is given to authorize Fletcher Academy or to the physician to exercise their best judgment as to the requirements of such diagnosis or treatment.

This consent shall remain in continuous effect until revoked in writing and delivered to the office of Fletcher Academy.

We hereby authorize any hospital, physician, or other person who has attended or examined the minor to furnish to the insurance company retained by the school any and all information with respect to an illness, medical history, consultation, prescriptions, or treatment, and copies of all hospital or medical records. A photostatic copy of this authorization shall be considered effective and valid at the original.

Date _____

Foreign Student's Guardian Signature _____

Father's Signature _____

Guardian's Address _____

Mother's Signature _____

Guardian's Phone (_____) _____ - _____

Student Accident Insurance

A secondary student accident insurance policy is provided for all students who have completed registration. The student is responsible for promptly reporting any injury to the academy office within 24 hours.

Worker's Compensation Insurance

Worker's Compensation insurance coverage is provided for all students while at work. A report of an injury must be made to the academy office within 24 hours.

Parents' Names _____
(Please Print)

Home Phone (_____) _____ - _____

Parents' Address _____

Father's Social Security # _____ - _____ - _____

Mother's Social Security # _____ - _____ - _____

Father's Place of Employment _____

Mother's Place of Employment _____

Father's Work Phone (_____) _____ - _____

Mother's Work Phone (_____) _____ - _____

Student's Social Security # _____ - _____ - _____

Student's Birth Date _____

Date of last Tetanus Booster _____

List all Allergies _____

Comments _____

Student's Insurance Information

Subscriber's Birth Date _____

Company _____

Policy # _____

Company Phone (_____) _____ - _____

Address _____

Please attach a front and back copy of your insurance card to the back of this form.