Medical Release Authorization

We, the parents/guardian of the undersigned student, do hereby authorize Padua Franciscan High School, Parma, Ohio, its staff, its host parents and counselors, as agents of the undersigned parents to consent to any x-ray examinations, anesthetic, medical or surgical diagnosis or treatment or hospital care which is deemed advisable by, and is rendered under the general supervision of any licensed physician or surgeon, whether such treatment or diagnosis is rendered at the office of said physician or surgeon or at a hospital.
It is understood that this authorization is not 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 the aforesaid agents to give specific consent to any and all such diagnosis, treatment of hospital care which the aforementioned physician or surgeon in the exercise of his/her best judgement may deem advisable.

Parent's Name:

Parent's Signature: Date:

Student's Name:

Student's Signature: Date:

Proof of Medical Insurance

Medical Insurance Provider:

Certificate Number (if available):

Group Number:

Subscriber's Name:

Phone Number of Insurance Provider:

Recommendation (s) as to how claims should be filed: