



MISSISSIPPI SCHOOL FOR MATHEMATICS AND SCIENCE

HEALTH CARE CONSENT FORM

AUTHORIZATION FOR:

Student Name: _____ Date of Birth: _____
Last First Middle

Social Security Number: _____ Gender: _____

Health Center Treatment Permission/Health Care Consent

In the case of illness, my son/daughter/ward _____ has permission to be treated at the Columbus Air Force Base Health Center doctors and staff (for military dependents only) and/or the Mississippi University for Women Health Center Doctor, Nurse Practitioner and Staff. Furthermore, I give my consent for my son/daughter/ward to attend and take part in residential counseling services provided by certified staff at MSMS.

IMPORTANT: If your child is a military dependent and is to be treated at Columbus Air Force Base, a limited power-of-attorney form must be completed and attached. Call the Student Affairs Office for more information on this if needed.

Furthermore, If my son/daughter/ward, needs medical, dental, optical or psychological treatment while attending MSMS, I give permission for transport by MSMS personnel or emergency services as deemed necessary. Additionally, I give permission for each diagnostic, therapeutic, or operative procedure as may be deemed necessary, and I accept financial responsibility for all treatment. I understand also that efforts will be made to contact me immediately if medical treatment is needed. I authorize officials of the MSMS to share any and all medical information in their possession with authorized medical personnel engaged in the care of my child.

PARENT/GUARDIAN INFORMATION: (Please print)

Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Fax _____ Email Address _____

DELEGATION OF AUTHORITY TO CONSENT TO HEALTH CARE:

I/We, being the parent(s) or legal guardian(s) of the above named minor student, hereby delegate to:

Name: The Mississippi School for Mathematics and Science

Address: 1100 College Street MUW 1627

City/State: Columbus, Mississippi 39701-5890

the authority to consent to health care services for the above-named minor child during the period from:

AUGUST 1, 2011 to **MAY 30, 2012**

Parent/Guardian Signature

(Military Dependents only) C A F B Authorizing Official – Printed Name

Address

(Military Dependents only) Signature of Authorizing Official

City State Zip

(Military Dependents only) Title and phone Number

Date

Date