



NORTHWOODS of IDAHO * CONSENT TO EXAMINATION, TREATMENT AND RELEASE OF INFORMATION

Student's Name _____
SSN # _____ Birthdate _____

I hereby authorize and consent to any X-ray examination, anesthetic, inoculation, vaccination, medical or surgical diagnosis, or treatment and hospital care to be rendered to the above named minor under general or special supervision and upon the advice of a physician licensed under the provisions of the Medical Practice Act. I hereby consent to X-ray examination, anesthetic, dental or surgical treatment and hospital care to be rendered to said minor by a dentist licensed under the provisions of the Dental Practice Act.

* RELEASE OF MEDICAL INFORMATION

I hereby authorize release of any medical or dental information regarding _____
to Northwoods.

Parent/Guardian Signature _____ Date _____

* MEDICAL INSURANCE

Proof of medical insurance must be provided upon enrollment.

Insurance company _____
Address _____
Phone _____ City _____ State/ZIP _____
Policy Holder _____ Policy Holder SSN # _____
Group # _____ Policy # _____ Policy Holder Birthdate _____

* DENTAL INSURANCE

Insurance company _____
Address _____
Phone _____ City _____ State/ZIP _____
Policy Holder _____ Policy Holder SSN # _____
Group # _____ Policy # _____ Policy Holder Birthdate _____

Please provide us with an enlarged front and back photocopy of your medical and dental insurance cards.