בס"ד

16601 Rinaldi Street
Granada Hills, CA 91344
PH:(818) 831-3000
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Medical Treatment Form

STUDENT INFORMATION

Student's last name:	First:	Middle:		
School phone no.: **(818) 831-3000**	SSN/Passport #:	Birth date:	Age:	Sex: ☑ M ❑ F
Mailing address: **16601 Rinaldi St.**	City/ State: **Granada Hills, CA**	ZIP Code: **91344**		

LIST SON'S PRESCRIBED MEDICATIONS, IF ANY				IF NONE
Name of medication	Strength	Frequency taken	Reason prescribed	My son has not been prescribed any medication in the past 2 years _____ Initial

INSURANCE INFORMATION

Person responsible for bill:	Birth date: / /	Address:	Home phone: ( )
Occupation:	Employer:	Employer address:	Employer phone: ( )

Please indicate primary insurance:		Student's relationship to subscriber: ❑ Self ❑ Child ❑ Other			
Subscriber's name:	Subscriber's SSN:	Birth date: / /	Policy #:	Group #:	Co-payment: $
Name of secondary insurance (if applicable):	Subscriber's name:		Policy #:	Group #:	
Student's relationship to subscriber:	❑ Self ❑ Child ❑ Other				

IN CASE OF EMERGENCY

Name of parents and local friend or relative (not living at same address):	Relationship to patient:	Home phone :	Cell :	Work phone :
	Father	( )	( )	( )
	Mother	( )	( )	( )
		( )	( )	( )

PARENT/GUARDIAN CONSENT

I,_____ , the parent/guardian of _____ , hereby authorize
Print Name Child's Name
J.E.T.S. and/or its agents to consent to any medical, surgical or psychological treatment, X-ray, or any other medical/hospital care when any or all of the foregoing is deemed advisable by, and is to be rendered under the general supervision of, any physician or surgeon licensed under the provisions of the Medical Practice Act. I waive my right to informed consent of treatment. The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the care provider. I understand that I am financially responsible for any balance. I also authorize J.E.T.S. or my insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

I _____authorize any information obtained during counseling to be shared
Students Name
between professional counseling, parents and JETS staff members.

*Student Signature*_____*Date*_____