Medical Treatment Authorization Form

General Information

Program Name: _____

Name: _____

Address_____

Date of Birth: _____ Age: _____ Sex: _____ Grade: _____

First Parent/Guardian Name: _____Relationship: _____

Best Phone (_____) _____ Work Phone: (_____) _____

Second Parent/Guardian Name: _____Relationship: _____

Best Phone (_____) _____ Work Phone: (_____) _____

If not available in an emergency, notify:

1. _____ Phone No.: __(_____)_____

2. _____ Phone No.: __(_____)_____

Health History

Any recurring illnesses or chronic conditions that could impact the child's participation in this program, including but not limited to allergies and/or medical or mental health conditions:

_____

_____

Operations or Serious Injuries (with dates):

_____

_____

Last Tetanus Shot: _____

Current Medications (Name / Dosage / Frequency / Reason)

_____

_____

[Note: The College does not distribute medications to children. If you have any questions or concerns or require a reasonable accommodation, please contact the Program Director: _____.]

Medical Insurance Information

Insurance Company:

_____

Insurance Company Phone Number:

_____

Policy Number:

_____

AUTHORIZATION FOR MEDICAL SERVICES

I, the parent/guardian of the child identified above, consent to my child's participation in the Program for which we are registering. I confirm that my child does not have any conditions that would prevent him/her from safely participating in and meeting the requirements of this program. I understand and agree that my child is required to maintain appropriate medical insurance throughout the Program and I agree to maintain such coverage. I assume full responsibility for the arrangement and cost of all medical services arranged for by the College of the Holy Cross, pursuant to this agreement. I understand that the College's policy is that it will not administer any medication, even over the counter, medication for my child.

I give permission to the College of the Holy Cross to provide routine health care; to order X-rays, routine tests, and treatment; to release any records necessary as related to such treatment; and to provide or arrange necessary related transportation for my child as it relates to the child's medical/mental health needs. In the event I cannot be reached in an emergency, I hereby give permission to the medical provider selected by the College to secure and administer treatment, including hospitalization for the child identified above.

I understand and agree that I have a responsibility to ensure the safety and well-being of all participants by keeping my child home in the event s/he is not feeling well or has been exposed to a communicable illness. I understand that the College has the right to refuse to admit and/or may dismiss a person who does not meet acceptable health conditions (such as, in the event of a temperature, contagious disease, etc.). In the event I am contacted for such reasons, I agree to pick up my child within thirty (30) minutes of such notice.

_____

Printed Name of Parent/Guardian Date

_____

Signature of Parent/Guardian