MEDICAL INFORMATION AND AUTHORIZATION

PERSONAL INFORMATION (please print):

Student's Name:____Grade Entering:__________Age: _____________

Date of Birth:_______________________Sex:_____________Weight:________________Height:__________________

Home Address:__________________________________City:___________________ State:_____ Zip:____________

Mother/Guardian:___________________Home Ph:_________Work:_________ Cell:_________ E-Mail:____________

Father/Guardian:____________________Home Ph:_________ Work:________Cell:__________E-Mail:____________

In case of emergency, if unable to reach parents/guardians, please contact:
Name: ______________________________Relationship to student:_______________________Phone:____________

HEALTH INFORMATION:
Please specify any known medical conditions including allergies: ____
____

Appliances, including contact lenses, glasses, braces: ____
____

Is student on daily medications of any kind, either at home or at school? If so, please list each medication: ______________
____

Date of last Tetanus Toxoid (must be current): __________________________________

I give the school nurse permission to share health information with my child's teacher(s), principal, or other staff involved with the care of my child _______________________ Yes _____________________No (**signature required**)

INSURANCE INFORMATION:
Name of Insured: ______________________________Policy # ______________________ID#___________________
Insurance Carrier: _________________________________Address: ____

AUTHORIZATION FOR EMERGENCY TRANSPORTATION AND TREATMENT:

Authorization is hereby granted by the undersigned to Heathwood Hall Episcopal School representatives or agents of Heathwood Hall Episcopal School (hereinafter collectively referred to as Heathwood Hall), under any circumstances considered by Heathwood Hall to be an emergency to arrange to transport by emergency medical personnel the above-named student to any hospital and to agree to and sign for any emergency medical treatment deemed necessary. The undersigned further agrees to pay for all medical expenses associated with such emergency medical treatment, and further releases from liability and agrees to hold harmless Heathwood Hall from any and all suits, claims, causes of action, or demands of any kind or character whatsoever arising from any damage, injury, or death occasioned at Heathwood Hall or activities under its supervision, and during travel for emergency treatment as authorized under this release or at the hospital, clinic, or physician's office during treatment.

This authorization includes the administration of such anesthetics, transfusions, intravenous medications, oral medications, and the performance of such diagnostic studies, including X-ray examinations and operative (surgical) procedures as advised by a duly licensed surgeon or physician chosen by Heathwood Hall if it is not possible to contact the parents/guardians or the physicians listed in this document.

If such an emergency arises where treatment at a hospital, clinic, or physician's office is necessary, please contact the following:

Physician:______________________________Phone:______________Address:_________________________________

Dentist:________________________________Phone:______________Address:_________________________________

Hospital Preferred:_______________________________Address:____

PARENT SIGNATURE:_______________________________________ **DATE**__________________________________

COMPLETE YEARLY AND RETURN WITH THE ENROLLMENT PACKET