PEAK

Experience the Learning

# Medical Authorization

**Personal Information:**

Participant Name: _____ Date: _____

Age: _____ Date of Birth: _____ Sex: _____ Weight: _____ Height: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ email address: _____

**In Case of Emergency Please Notify:**

1. Name: _____ Relationship: _____

Cell Phone: _____ email address: _____

2. Name: _____ Relationship: _____

Cell Phone: _____ email address: _____

**Medical Condition:**

Please specify any known medical conditions that may affect or inhibit participation in a strenuous, physically active, outdoor program (athletic injuries like strains or sprains, orthopedic injuries, infectious diseases, heart murmurs, epilepsy, heart disease, high blood pressure, diabetes, asthma, bleeding or clotting disorders, allergies or allergic reactions to medications or food, etc.):

_____

_____

Is the participant on any daily medications of any kind? If so, please list each one:

_____

_____

**Immunizations:**

Date of last Tetanus or Tetanus booster (must be current): _____

## 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 transport the above - named participant to any hospital, clinic or physicians office and to agree to sign for any emergency medical treatment deemed necessary. The undersigned further agrees to pay all medical expenses not covered by school insurance, associated with such emergency medical treatment and further releases from liability and agrees to hold harmless Heathwood Hall and the PEAK program 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 Episcopal School, 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 impossible to contact physicians listed in this document or if they are unavailable for consultation.

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

### Physician:

Name: _____

Address: _____ Phone: _____

### Dentist:

Name: _____

Address: _____ Phone: _____

### Hospital or Clinic Preferred:

Name: _____

Address: _____ Phone: _____

### Insurance Information:

Are you covered by a health or accident insurance policy? _____ Yes _____ No

Name of Insured: _____ ID#: _____

Insurance Carrier: _____

Address: _____

Policy #: _____

Signature: _____ Date: _____

***Please bring this form to the program or return it to:***

**The PEAK Program * 3000 South Beltline Boulevard * Columbia, SC * 29201**