



**THE WOODHALL SCHOOL**  
 ACADEMIC YEAR 2016 – 2017  
**CONSENT TO MEDICAL TREATMENT &  
 HEALTH SUMMARY**

**HEALTH**

This form constitutes a medical history and permission statement that must be completed on both sides and signed by a parent or guardian. All of the information on this form is confidential and will be used only for the purpose of evaluating your child's health status and facilitating medical diagnosis, care, and/or treatment for him or for the processing of insurance claims in connection therewith.

STUDENT NAME \_\_\_\_\_ BIRTHDATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_

ADDRESS \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

**PARENT/GUARDIAN**  
 Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 Home ☎ \_\_\_\_\_ Cell ☎ \_\_\_\_\_  
 Work ☎ \_\_\_\_\_ DOB \_\_\_\_\_  
 Email \_\_\_\_\_

**PARENT/GUARDIAN**  
 Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 Home ☎ \_\_\_\_\_ Cell ☎ \_\_\_\_\_  
 Work ☎ \_\_\_\_\_ DOB \_\_\_\_\_  
 Email \_\_\_\_\_

**ALTERNATIVE EMERGENCY CONTACTS (Other than parents)**

Name \_\_\_\_\_  
 Relationship to student \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 Home ☎ \_\_\_\_\_ Cell ☎ \_\_\_\_\_

Name \_\_\_\_\_  
 Relationship to student \_\_\_\_\_  
 Address \_\_\_\_\_  
 \_\_\_\_\_  
 Home ☎ \_\_\_\_\_ Cell ☎ \_\_\_\_\_

**PRIMARY CARE INFORMATION**

Physician's name \_\_\_\_\_ Phone \_\_\_\_\_

Dentist's name \_\_\_\_\_ Phone \_\_\_\_\_

**MEDICAL INFORMATION**

Date of last tetanus booster \_\_\_\_ / \_\_\_\_ / \_\_\_\_ FOR SCHOOL NURSE Does your child have allergies?  Y  N Anaphylaxis  Y  N

Allergies \_\_\_\_\_

For severe allergies, provide "Emergency Health Care Plan" Prescribed Epi-pen?  Y  N

Medical conditions/ limitations (i.e. asthma) \_\_\_\_\_

Previous hospitalizations/ surgeries (include dates) \_\_\_\_\_

Current medications (including dose) \_\_\_\_\_

**INSURANCE INFORMATION**

Health Insurance Company \_\_\_\_\_

Group # \_\_\_\_\_ ID # \_\_\_\_\_

Policy Holder Name \_\_\_\_\_ DOB \_\_\_\_\_

Does this Policy require pre-authorization of non-emergency services?  Yes  No

PLEASE ATTACH A CLEAR COPY OF STUDENT'S INSURANCE CARD (FRONT **AND** BACK)

**PERMISSION AND RELEASES**

I hereby give The Woodhall School ("TWS") the authority to obtain any necessary medical treatment for my child, if in the judgment of its employees medical treatment is required. I give the school nurse or TWS employee, permission to administer an Epi-Pen in the event of a severe allergic or anaphylactic reaction.

I give my permission to TWS to release medical information to school staff/faculty and health care providers to provide medical attention to my son. I also give my permission to staff/faculty to provide medical care and treatment, including, but not limited to the dispensation of prescription and non-prescription (over the counter) medication to my son.

In the event of an emergency, I authorize the school employee to act on my behalf when seeking medical treatment. I understand that all reasonable attempts will be made to contact me in advance of treatment, provided medical circumstances permit. In the event I cannot be reached, I authorize medical treatment as deemed necessary by the school nurse, school administrator, a school official and/or the treating hospital or other health care provider. I authorize TWS to release information to facilitate the medical or surgical care of my child, or as is necessary to complete a claim for health insurance.

In the event my child takes an overnight leave, I give consent to the Health Office to dispense my child's prescribed medications to a responsible adult or student if over the age of 18 to administer.

I acknowledge due to the unique nature of a boarding school, it may be necessary to discuss and provide information about the health of your son with pertinent faculty members to assure the health and safety of your son.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Signature of Student (if over 18 years of age or will be by June 2017)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date