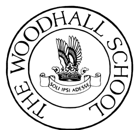

THE WOODHALL SCHOOL

HEALTH

ACADEMIC YEAR 2017 – 2018

CONSENT TO MEDICAL TREATMENT & HEALTH SUMMARY

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 ______________________________

BIRTH CITY______________________________ HOSPITAL______________________________

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 _____/_____/_____ Does your child have allergies? ☐ Y ☐ N Anaphylaxis ☐ Y ☐ N

FOR SCHOOL NURSE

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) ______________________________

____

____

____

CONTINUED ON BACK

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