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

Chronic Conditions, Recurring Illnesses

____

____

Operations or Serious Injuries (with dates):

____

____

Allergies:

____

____

[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

/U šZ ‰ Œ vš lPµ Œ] v }(šZ Z]o] vš](] }À U }v• vš š} uÇ Z] 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 }oo P [• ‰}o] Ç]• šZ š]š Á]oo