

**Brewster Academy 2008-2009 Medical Authorization** Health Center Phone 603 569 7121 Fax 603 569 7144

This form constitutes a permission statement that **must** be completed and signed by a parent or guardian **and** by the student.

Student's name \_\_\_\_\_ Birth date \_\_\_\_\_ Soc. Sec. \_\_\_\_\_

Home address \_\_\_\_\_  
*Number and street City State Country Zip Code*

\_\_\_ Male \_\_\_ Female \_\_\_ Day \_\_\_ Boarding \_\_\_ Grade Student cell phone \_\_\_\_\_

Student resides with: Both Parents \_\_\_ Father \_\_\_ Mother \_\_\_ Other (specify) \_\_\_\_\_

**Father/Guardian's** full name \_\_\_\_\_ Res.phone \_\_\_\_\_

Address \_\_\_\_\_ Bus.phone \_\_\_\_\_

\_\_\_\_\_ Cell phone \_\_\_\_\_

E-mail Address \_\_\_\_\_ Fax phone \_\_\_\_\_

**Mother/Guardian's** full name \_\_\_\_\_ Res.phone \_\_\_\_\_

Address \_\_\_\_\_ Bus.phone \_\_\_\_\_

\_\_\_\_\_ Cell phone \_\_\_\_\_

E-mail Address \_\_\_\_\_ Fax phone \_\_\_\_\_

**Health insurance is required for all students. Attach a copy of front & back of insurance card.**

Policy holder Name (**required**) \_\_\_\_\_ Policy holder DOB (**required**) \_\_\_\_\_

Does your insurance carrier require a physician referral or prior authorization for medical treatment? \_\_\_\_\_

**Confidentiality**

We respect the privacy of a student's medical care, yet we urge students to communicate with parents about their medical circumstances. Parents and students agree, as a condition of enrollment, to consent to the release of any of the student's records, including information relating to drug or alcohol treatment and testing and mental health records, to faculty and administrators at Brewster Academy, and their agents, with a need to know when a health care professional at Brewster Academy has determined such release is in the best interests of the student and/or the community.

**Medical Authorization**

I hereby consent for the Director of Health Services at Brewster Academy to direct health care providers to carry out accepted procedures for diagnosis, immunization, medical and minor surgical treatment or counseling for my child while attending school. I authorize the Health Center to share necessary and appropriate medical information with the treating physician and to release information necessary to process insurance claims. I authorize the nursing staff to administer OTC and prescription medication as directed and to provide medication to my child for self-administration if needed. I also give permission for my child's immunizations to be completed in accordance with all applicable laws and the cost to be charged to my account.

**Emergency Medical Authorization**

In rare instances when any emergency arises and where delay might jeopardize the recovery of my child, I hereby authorize the appropriate physicians or surgeons to give necessary anesthesia and perform emergency surgery on my child. I understand that in the event of an emergency, the School will use all reasonable efforts to contact me as soon as possible.

**Persons treating my child should be aware of the following Allergies or Medical Conditions:**

\_\_\_\_\_  
Signature of parent/guardian x \_\_\_\_\_ Date \_\_\_\_\_

I consent to the foregoing authorization granted by my parent/guardian x \_\_\_\_\_ Date \_\_\_\_\_  
Signature of student