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

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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