



**CONSENT FOR EMERGENCY HEALTH CARE**  
**(To be completed in black ink by parent)**

STUDENT'S NAME \_\_\_\_\_ GRADE \_\_\_\_\_

LAST

FIRST

MIDDLE

1. Please list all allergies (i.e., medication, environmental, insects, food): \_\_\_\_\_

2. Please indicate any special needs or conditions of which we should be aware: \_\_\_\_\_

3. Please list any medication your child takes on a regular basis: \_\_\_\_\_

**MEDICAL/HOSPITALIZATION INSURANCE (We provide International students with insurance.)**

Name of Insurance Company \_\_\_\_\_

Claims Address \_\_\_\_\_

ID/Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policyholder's Full Name \_\_\_\_\_

Policyholder's Date of Birth \_\_\_\_\_ Policyholder's Social Security # \_\_\_\_\_

Does the insurance company require pre-authorization?  Yes  No Telephone # (\_\_\_\_) \_\_\_\_\_

PREFERRED HOSPITAL \_\_\_\_\_

PHYSICIAN \_\_\_\_\_ PHONE \_\_\_\_\_

ORTHOPEDIST \_\_\_\_\_ PHONE \_\_\_\_\_

DENTIST \_\_\_\_\_ PHONE \_\_\_\_\_

ORTHODONTIST \_\_\_\_\_ PHONE \_\_\_\_\_

The Bolles School is required by HIPAA (the Federal Health Insurance Portability and Accountability Act) to preserve the privacy of your child's health information. In accordance with this policy, access to all student health forms is limited to the School nurse or administrative staff, and is only utilized for the safety and protection of your child or in an emergency.

I authorize the School nurse or the faculty/staff of The Bolles School to obtain such professional medical/surgical care or hospital services as may appear to be necessary or desirable for the protection of the health or life of my minor child, named above. Any person rendering health care pursuant to this authorization shall be entitled to treat this consent as having been given to such person. I further understand that The Bolles School will, in any event where emergency room or hospital treatment for a student is indicated, use due and prompt diligence to notify and consult with a parent or guardian. I further agree to pay and to hold The Bolles School harmless on account of any reasonable medical, dental, hospital, or other related charges incurred on behalf of the patient.

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