



PERMISSION FOR MEDICAL CARE

Prospective Student Weekend

RETURN NO LATER THAN ONE WEEK BEFORE PROGRAM

I hereby authorize the medical staff of the American Hebrew Academy Student Health Center or their designates, to carry out the necessary procedures for diagnosis, medical treatment, and minor surgical treatment for:

Participant's Name _____ DOB _____ Social Security _____
(Please print full name)

Parent/Legal Guardian _____ Date _____
(Please print full name)

Signature of Parent/Legal Guardian _____ Relationship _____

In rare instances, a medical, psychiatric, or surgical emergency requiring immediate treatment arises in which written consent by parents or guardians is legally required, but the parent or legal guardian is not available. In order to avoid delays that could jeopardize the life, welfare, or recovery of a student in such a situation, we request that the parents or guardian grant the following permission with the understanding that every effort will be made to contact you in an emergency.

I hereby grant permission to medical personnel rendering care to my child while at the American Hebrew Academy or the American Hebrew Academy Health Center staff to grant permission and consent for emergency medical or psychiatric evaluation/treatment, including, but not limited to diagnostic, drug, and/or alcohol testing and/or surgical procedures on

Participant's Name: _____
(Please print full name)

in the event that he/she is unable to contact me when further delay might jeopardize life or welfare or impair recovery. I further give the American Hebrew Academy Student Health Center staff permission to release pertinent health information concerning my child to the treating hospital and/or physician, and to give the treating hospital and/or physician permission to release copies of all medical records, laboratory, and radiology reports to the American Hebrew Academy Student Health Center as well as to communicate my child's progress by telephone to health care providers at the American Hebrew Academy.

I agree that I (we) will be responsible for any medical/pharmaceutical costs incurred that are not covered by medical insurance. I also agree that the American Hebrew Academy, including its trustees and employees, or those medical professionals designated by the medical advisor or his/her designates will not be liable for unknown or unforeseen conditions arising from medical/nursing treatment or medications received by my son/daughter.

Parent/Legal Guardian _____ Date _____
(Please print full name)

Signature of Parent/Legal Guardian _____ Relationship _____

(Please turn page over and complete the backside)

MEDICATIONS to be taken while at AHA:

All medications should be in their original pharmacy labeled containers, labeled properly (how and when it is to be given). These must be given to our staff upon arrival.

Medications: Name, dose, times to administer:

1. _____
2. _____
3. _____

ALLERGIES

For the benefit of treating physicians, please list all medications/foods to which your child is known to be allergic. Also, please elaborate on the type of reaction s/he is likely to have.

Date of last **Tetanus** shot : _____

Please list any health issues (chronic, mental-health related and/or recent illnesses): _____

Is there any other information a medical provider should know prior to treating your child?

CONTACT NUMBERS

Please list telephone/cell phone and pager numbers for each parent/legal guardian:

Other contact information

Name _____	Name _____	_____
Address _____	Address _____	_____
_____	_____	_____
Relationship _____	Relationship _____	_____
Home Phone _____	Home Phone _____	_____
Business Phone _____	Business Phone _____	_____
Cell Phone _____	Cell Phone _____	_____
Pager _____	Pager _____	_____
Fax _____	Fax _____	_____
Other _____	Other _____	_____

Please list telephone/cell phone number for any additional contact individuals if parents cannot be reached:

Name _____ Relationship _____ Phone _____

HEALTH INSURANCE INFORMATION

Please complete the request for information below and **attach an ENLARGED and LEGIBLE copy of parent's insurance card, (front and back)**, for health insurance coverage you maintain for your child.

Name of Insured _____ Date of Birth (insured parent) _____

Home Phone _____ SS# _____

Home Address _____

Relationship to Patient _____

Employer _____

Employer's Address/Phone _____

Insurance Company _____

Is this a PPO? _____ HMO? _____ Other? _____

Insurer's Address/Phone _____

Policy, Group and/or ID# _____

I hereby grant permission to the American Hebrew Academy Student Health Center or to any hospital or physician designated by them, to submit and to collect from my insurance carriers any and all appropriate charges that are incurred for services rendered to my child. I further grant permission for the release of any medical information necessary to process said claims for my child.

Parent/Legal Guardian _____ Date _____

(Please print full name)

Signature of Parent/Legal Guardian _____ Relationship _____

Return NO LATER THAN ONE WEEK BEFORE PROGRAM to:

American Hebrew Academy Admissions Department

ATTN: Prospective Student Weekend

Fax: 336-217-7011

Email: info@americanhebrewacademy.org