DARROW SCHOOL MANDATORY PERMISSION FOR TREATMENT

Parent or Guardian to Complete **Boarding Student_____ Day Student_____**

Student's Name	Social Security #	Age/Grade	Sex	Date of Birth

Parent's Name	Address	Telephone/Fax/E-mail
		H:
		W:
		Cell:
Occupation:		Fax:
		E-mail:

Parent's Name	Address	Telephone/Fax/E-mail
		H:
		W:
		Cell:
Occupation:		Fax:
		E-mail:

	Name	Relationship	Telephone
Mandatory emergency contact other than listed above			H:
			W:
			H:
			W:

<u>Please Read Carefully Before Signing</u>

I, _____, am hereby authorizing Darrow School's Health Services Center to provide general health care and counseling to _____, my son/daughter, as needed while attending Darrow School. I understand that this permission covers the Nurse(s), Advisor(s), Counselor(s), Faculty and the Administration of the school and also the area Physician(s), Dentist(s), Counselor(s), Psychologist(s), Clinic(s) and Hospital(s) to provide any of all of the following care: Advisor/Advisee sessions, Medical counseling, General Health Maintenance, Group Counseling, Faculty Discussions, Health Seminars, Evaluations-Psychological or Medical, Curative or Maintenance Counseling, Crisis Counseling, Emergency Medical or Psychological Care and possible admissions to area hospitals as needed. This permission will also cover obtaining alcohol and drug screening and the results of such testing, as deemed necessary by Darrow School.

I realize that in the event of an emergency, the Health Services Center will attempt to reach me or the emergency contact so named for verbal consent for treatment, and if both are still unavailable, I am authorizing any and all of the following:

1. Initial evaluation and commencement of treatment at the school.
2. Admission to area facilities (Hospitals, Crisis Centers).
3. Medications as needed.
4. Emergency treatment and /or surgery and anesthesia to perform emergency surgery.

I understand that when emergency care has been given off school grounds, I will be contacted by the school or the faculty utilized to report the outcome. However, I realize that when general medical care is given at Darrow Health Services, my child will report the results unless the nurse feels it is more appropriate for her to do so.

I understand that I will be contacted, whenever possible, before initial counseling or evaluative appointments are made by the Health Services Center. I realize, however, that in the event of an emergency, I will be contacted as soon as possible, but that it may be after the session. I further understand that the counselor from Darrow Health Services will contact me by phone after initial consultation and periodically thereafter to discuss my child's status and schedule of appointments. I agree that the counselor and the Health Services staff will maintain confidentiality with my child unless it is in some way contraindicated, at which time it will be broken only after my child has been informed of the same.

I agree to pay all appropriate billings on arrival and will obtain reimbursement from my health insurance company. I understand that the bills will be sent to the address noted herein as the responsible party.

I agree that this permission will be considered binding by the school and all area facilities until my child has withdrawn from Darrow School and that if I choose to revoke this permission, I will contact the Health Services Center in writing. I further understand that this permission is a mandatory part of my child's Health Record and is necessary for continued enrollment at Darrow School.

Signature:_____Relationship:_____Date:_____

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INSURANCE AND MEDICAL BILLING INFORMATION

Please make a photocopy of any insurance cards you have for your child (front and back), to include medical insurance, prescription plans, and dental plans. Providing us with updated detailed information on insurance coverage will help to insure accurate billing when and if your child requires treatment while at school.

Please fill out insurance subscriber information for most accurate insurance billing. If student is not covered by insurance please indicate who responsible party will be for medical bills.

Subscriber/Responsible Party	Relationship to student	Date of Birth	Social Security Number:
			Address:

If unable to make a photocopy of insurance cards please provide the following regarding your insurance coverage:

MEDICAL:

Insurance Co. and Address	ID#:	Co-Pays (if applicable)
	Group#:	
	Plan#:	
	Ins. Co. Phone #:	

DENTAL:

Insurance Co. and Address	ID#:	Co-Pays (if applicable)
	Group#:	
	Plan#:	
	Ins. Co. Phone #:	

PRESCRIPTION PLAN:

Insurance Co. and Address	ID#:	Co-Pays (if applicable)
	Group#:	
	Plan#:	
	Ins. Co. Phone #:	