



Note: A Parent or Guardian must complete and sign this form.



Parental Authorization to Treat Form Landmark School Health Center

Student Name: _____ Date of Birth (DOB): ___/___/___ Sex: ___ Age: ___

Parent or Guardian: _____ Home Phone: () _____ Cell: () _____
Work Phone: () _____

Address: _____

If not available, in an emergency contact:

1. _____ Phone: () _____
2. _____ Phone: () _____

Health History: (Circle or fill-in where applicable)

Ear Infections	Y	N	Allergies	Hay Fever	Y	N	Food Allergies	Nuts, Type	_____	Diseases	Chicken Pox	_____	
Convulsions	Y	N	Ivy Poisoning, etc.	Y	N	Beans	_____	Measles	_____	Mumps	_____	Rheumatic Fever	_____
Diabetes	Y	N	Insect Stings	Y	N	Dairy	_____	Seafood	_____	Other	_____		
Asthma	Y	N	Penicillin	Y	N	Other	_____						
Mononucleosis	Y	N	Other Drugs	Y	N	Specify	_____						

Last Tetanus Booster: _____

Operations or Serious Injuries (Dates): _____

Chronic or Recurring Illnesses: _____

Any Family History of Epilepsy, or Other Neurological or Emotional Disorders: _____

Athletic Information: list any fractures, sprains, concussions or bone dislocations: _____

Psychological climate at home: _____ Psychiatric Counseling? Y N

Does student take medication daily? **If yes, please list medications:** _____

Name of Health Insurance: _____ Policy Number: _____

Subscriber's Name: _____ Subscriber's SS #: _____ Subscriber's DOB: ___/___/___

Prescription Plan (if applicable): _____

Please copy Both Sides of Insurance Card & Prescription Drug Card and attach to this form, along with a letter of referral from your primary care physician for emergency care, if necessary.

PARENT'S AUTHORIZATION: This health history is correct so far as I know, and the person herein described has permission to engage in all prescribed school activities, except as noted by me and the examining physician. I give permission for members of the Landmark School to administer first aid, medications, or any other assistance they consider to be in the best interests of my child. In the event of an emergency, I hereby give permission to the physician selected to hospitalize, secure proper treatment for and to order injection, anesthesia or surgery for my child as named above. I hereby authorize the Landmark School physician to examine my child and prescribe medications as he/she deems necessary.

Parent/Guardian Signature: _____ **Date:** _____