Parental Authorization to Treat Form

Parent/Guardian must complete and sign this form

Student Name_____ Date of Birth (DOB)____/____/____ Sex_____ Age_____

Parent(s)/Guardian(s) _____
Primary Phone/Name_____ Secondary Phone/Name_____
Address _____City_____ State _____ Zip_____
If not available, in an emergency contact:

1. _____ Phone _____
2. _____ Phone _____

Health History (Please fullly complete)

Asthma Y ☐ N ☐ Inhaler Y ☐ N ☐
Diabetes Y ☐ N ☐
Ear Infections Y ☐ N ☐
Mononucleosis Y ☐ N ☐
Seizure Disorder Y ☐ N ☐

Allergies EpiPen Y ☐ N ☐ Last Used _____
Drugs Y ☐ N ☐ List: _____
Foods Y ☐ N ☐ List: _____
Insects Y ☐ N ☐ List: _____
Environmental Y ☐ N ☐ _____

Date of Last Tetanus Booster _____

List and Date - Serious and/or Chronic Illnesses and Injuries/Surgeries _____

List and Date - **Concussions**, bone dislocations/fractures or sprains _____

If necessary, Landmark is authorized to obtain emergency dental/orthodontic treatment. YES____ NO____

Family history of Epilepsy, or other Neurological/Emotional Disorders? YES____ NO____

Psychological climate at home_____ Psychiatric Counseling? YES____ NO____

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

_____

Health Insurance Plan _____ Subscriber Name _____ DOB ____/____/____

Health Ins Policy # _____ **Prescription Plan** _____

Please copy Both Sides of Insurance Card & Prescription Drug Card and attach to this form

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**_____

Submit via email, mail or fax:

Landmark Medical Forms
PO Box 227
Prides Crossing, MA 01965

MedicalForms@landmarkschool.org

FAX 978-921-0361