

DATE _____

THIS HEALTH HISTORY IS CORRECT SO FAR AS I KNOW, AND THE PERSON HEREIN DESCRIBED HAS PERMISSION TO ENGAGE IN ALL PRESCRIBED ACTIVITIES EXCEPT AS NOTED.

AUTHORIZATION FOR TREATMENT:

I HEREBY GIVE PERMISSION TO THE MEDICAL PERSONNEL SELECTED BY THE SCHOOL TO ORDER X-RAYS, ROUTINE TESTS, TREATMENT; TO RELEASE ANY RECORD NECESSARY FOR INSURANCE PURPOSES; AND TO PROVIDE OR ARRANGE NECESSARY RELATED TRANSPORTATION FOR ME/OR MY CHILD. IN THE EVENT I CANNOT BE REACHED IN AS EMERGENCY, I HEREBY GIVE PERMISSION TO THE PHYSICIAN SELECTED BY THE SCHOOL TO SECURE AND ADMINISTER TREATMENT, INCLUDING HOSPITALIZATION, FOR THE PERSON NAMED ABOVE.

NAME OF INSURED _____

HEALTH INSURANCE CO. _____

ID # _____

Physician's Name _____ Phone # _____

Signature of Parent _____ **Date** _____

Please submit a copy of your insurance card (both sides) in order to ensure that we are able to get treatment for you child in case of an emergency.