



**Note: A Physician 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: (    ) \_\_\_\_\_

Work Phone: (    ) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

If not available, in an emergency contact:

1. \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

2. \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: (    ) \_\_\_\_\_

### Health History: (Check or fill-in where applicable)

#### Allergies

Ear Infections: Y <input type="checkbox"/> N <input type="checkbox"/>	Drugs: Y <input type="checkbox"/> N <input type="checkbox"/> Name: _____	EPI Pen Y <input type="checkbox"/> N <input type="checkbox"/> For: _____
Convulsions: Y <input type="checkbox"/> N <input type="checkbox"/>	Foods: Y <input type="checkbox"/> N <input type="checkbox"/> Name: _____	Last Time Used: _____
Diabetes: Y <input type="checkbox"/> N <input type="checkbox"/>	Insects: Y <input type="checkbox"/> N <input type="checkbox"/> Name: _____	Inhaler: Y <input type="checkbox"/> N <input type="checkbox"/>
Asthma: Y <input type="checkbox"/> N <input type="checkbox"/>	Environmental: Y <input type="checkbox"/> N <input type="checkbox"/>	
Mononucleosis: Y <input type="checkbox"/> N <input type="checkbox"/>		

**Last Tetanus Booster:** \_\_\_\_\_

Operations or Serious Injuries (Dates): \_\_\_\_\_

Chronic or Recurring Illness: \_\_\_\_\_

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

**Athletic Information:** list any fractures, sprains, **Concussions**, 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 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:** \_\_\_\_\_