University School of the Lowcountry (2023-2024)
MEDICAL INFORMATION AND AUTHORIZATION

PERSONAL INFORMATION (please print):

Student's Name: _____ Grade Entering: _____ Age: _____

Date of Birth: _____ Gender: _____ Weight: _____ Height: _____

Home Address: _____ City: _____ Zip: _____

Mother/Guardian: _____ Home Ph#: _____ Work: _____

Cell: _____ E-Mail: _____

Father/Guardian: _____ Home Ph#: _____ Work: _____

Cell: _____ E-Mail: _____

In case of emergency, if unable to reach parent(s)/guardian(s), please contact:

Name: _____ Relationship to student: _____ Phone: _____

HEALTH INFORMATION:

Please specify any known medical conditions, including allergies: _____

_____

Appliances, including contact lenses, glasses, braces: _____

_____

Is student on daily medications of any kind, either at home or at school? If so, please list each medication:

_____

Date of last Tetanus Toxoid (must be current): _____

I give the school's administration permission to share health information with my child's teachers and other staff involved with the care of my child **(signature required)** _____ Yes _____ No

INSURANCE INFORMATION:

Name of Insured: _____ Policy #: _____ ID# _____

Insurance Carrier: _____ Address: _____

AUTHORIZATION FOR EMERGENCY TRANSPORTATION AND TREATMENT:

Authorization is hereby granted by the undersigned to University School of the Lowcountry representatives or agents of University School of the Lowcountry (hereinafter collectively referred to as University School), under any circumstances considered by University School to be an emergency to arrange to transport by emergency medical personnel the above-named student to any hospital and to agree to and sign for any emergency medical treatment deemed necessary. The undersigned further agrees to pay for all medical expenses associated with such emergency medical treatment, and further releases from liability and agrees to hold harmless University School from any and all suits, claims, causes of action, or demands of any kind or character whatsoever arising from any damage, injury, or death occasioned at University School or activities under its supervision, and during travel for emergency treatment as authorized under this release or at the hospital, clinic, or physician's office during treatment.

This authorization includes the administration of such anesthetics, transfusions, intravenous medications, oral medications, and the performance of such diagnostic studies, including X-ray examinations and operative (surgical) procedures as advised by a duly licensed surgeon or physician chosen by University School if it is not possible to contact the parents/guardians or the physicians listed in this document.

If such an emergency arises where treatment at a hospital, clinic, or physician's office is necessary, please contact the following:

Physician: _____ Phone: _____ Address: _____

Dentist: _____ Phone: _____ Address: _____

Hospital Preferred: _____ Address: _____

PARENT SIGNATURE: _____ DATE: _____