



2010 PERMISSION TO TREAT FORM

Student Name: _____

Social Security Number _____ - _____ - _____ Date of Birth (month/day/year): _____ / _____ / _____

List all known allergies: _____

List active medical conditions (e.g. diabetes, asthma): _____

Recent psychiatric, psychological care: No Yes _____

Current Medications (student must have a signed Prescription Medication Order to receive these): _____

Primary physician name: _____ Phone: _____

Every effort is made to contact and inform the parents or guardians in case of a medical emergency, serious injury or surgical illness when immediate intervention is necessary. On rare occasions parents or guardian cannot be reached. Accordingly, parents or guardian are requested to sign the following:

We/I _____ hereby give permission to The Putney School and its authorized agents in the event of illness or accident to our/my son/daughter _____ to secure and provide medical, dental, or surgical care and treatment for him/her. We hereby give permission and authorize The Putney School, its authorized personnel, or agents and those physicians, surgeons, and dentists retained by the school, to give, administer, and render any treatment or aid, including anesthesia or surgery, as necessary to protect, preserve and safeguard our/my son/daughter's life and/or health. We/I further authorize The Putney School through its Health Service personnel to release information to facilitate the medical or surgical care of our/my son/daughter and as is necessary to facilitate the release of information for the completion of a claim for health insurance. We/I release The Putney School from any financial responsibility for the above-referenced treatment.

Parent/legal guardian's signature Date

Parent/legal guardian's signature Date

Parent/legal guardian's signature Date

Parent/legal guardian's signature Date

Mailing Address

Mailing Address

City/State/Zip

City/State/Zip

Home Phone Business Phone

Home Phone Business Phone

Cell Phone Email

Cell Phone Email

In case of emergency, if we are unable to contact either of the above:

1st Emergency Contact (name, phone): _____

2nd Emergency Contact (name, phone): _____

HEALTH BILLING INFORMATION

Name of person responsible for payment _____

Home address of this person _____

City _____ State _____ Postal Code _____ Country _____

Home telephone: _____

***** Please enclose a copy of the front and back of the student's health insurance card. *****