MEDICAL, DENTAL AND PSYCHIATRIC CONSENT FORM

I (we), parent(s) or legal guardian of ___________________________________,
(Student's name)
Who is a student at The Taft School, Watertown, CT, hereby authorize the Health Center staff at the school to administer to my (our) child any medical/dental/psychiatric care, treatment or medication deemed advisable by a physician licensed by the State of Connecticut or by any other qualified health professional under the general supervision of a licensed physician. I (we) further consent to the immediate transfer of my (our) child to any hospital or other medical facility or office in the event of an urgent or emergent medical, dental or psychiatric condition, and authorize a representative of the school to consent on my (our) behalf to any urgent or emergent medical, dental or psychiatric treatment to be rendered to my (our) child.

I (we) further authorize any physician or health care provider who has rendered treatment to my (our) child to release to the Health Center any and all medical records relating to or necessary for my (our) child's treatment or diagnosis, in order to enable it to provide treatment for the physical and mental health of my (our) child.

I (we) authorize the school to release information to facilitate the medical, dental, psychiatric care of my (our) child or as is necessary to enable the provider of care to complete a claim for health insurance. I (we) understand and agree that I (we) are exclusively responsible for the payment of all medical services rendered to my (our) child other than services provided directly by the health center.

The school assures the parent(s) or legal guardian that all reasonable efforts to contact them will be made before exercising this authorization. This consent will remain in effect as long as our child is a student at Taft.

Permission to give flu shot: Yes No Permission to give immunizations: Yes No

Date of Birth ___/___/___ Tetanus Booster (most current date) ___/___/___

Allergies _________________ Medications ________________________________

Chronic Major Illness______________________________

Today's Date ___/___/___ ____
Parent or Guardian signature

Home phone (______) ______________ Business phone (______) ____________________
Cell phone (______) _____________________

Home Address ____

INSURANCE INFORMATION (required)

Insurance company____

Insurance Co. address ____

Employer providing insurance_______________________________

Primary Group # _______________________ Membership ID #____________________

Policy Holder_______________________________ Date of Birth ___/___/___

Policy Holder SS# _____/___/_____ Relationship to student ______________