The Putney School SUMMER ARTS

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2019 EMERGENCY INFORMATION & PERMISSION TO TREAT

Student Name:________________________________

Date of Birth:________________ **Primary Language:**________________ **Preferred Name:**________________
month / day / year

Sex: ❑ Female ❑ Male ❑ Non-binary Gender Identity:________________ **Last Tetanus:**________________

Allergies:________________________________

Pertinent Medical History/Info:________________________________

Medications:________________________________

Primary physician:________________________ **Phone:**________________

PERMISSION TO TREAT: We/I________________________**(parent/guardian name)** hereby give permission to THE PUTNEY SCHOOL and its authorized agents in the event of illness or accident to our/my child,________________(**student name**), to secure medical, mental health, dental, or surgical services/treatment for him/her/them. We hereby give permission and authorize THE PUTNEY SCHOOL, its authorized personnel or agents, and those physicians, practitioners, surgeons, and dentists enlisted 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 child's life and/or health.
We/I further authorize The Putney School through its Health Services personnel to release information to facilitate the medical or surgical care of our/my child 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.

USE/ DISCLOSURE INFORMATION: This form authorizes Health Services, counseling staff and community health care providers to whom the student is referred for health care to use and disclose to each other the student's health information in order to evaluate whether accommodations at school are recommended or necessary in order to address the student's health-related condition and/or to provide the student's health information to school administration including the head of school to the extent necessary to make their above mentioned recommendation. The Health Insurance Portability and Accountability Act of 1996 (HIPPA) requires that you be informed that, by signing this form, you authorize the use/disclosure of the student's health information as described above. This authorization shall become effective immediately and remain for one year following the child's last day of attendance. You have the right to revoke this authorization at any time. Revocation must be in writing, signed by a parent/guardian and delivered to Health Services. I understand that The Putney School will protect the student's health information as prescribed by the Family Educational Rights and Privacy Act (FERPA) and that the information becomes part of the student's health record. The information will be shared with individuals working at or with The Putney School for the purpose of providing safe and appropriate health care for the student.

Parent/Guardian Signature:________________________________

Parent/Guardian Name:________________________________

Person responsible for payment:________________________________

Address:________________________________
Street City State Postal Code Country

Home Phone:________________________ **Cell Phone:**________________________

Email:________________________________

Alternate Emergency Contact:

Name: ________________________________

Phone Number: ________________________ **Email:** ________________________