ACADEMY OF THE HOLY FAMILY

54 West Main Street * Baltic, Connecticut 06330 * Telephone: (860) 822-9272 * Fax: (860) 822-1318
Health Aide: Mrs. Patricia C. Penney * E-Mail: ppenney_health@ahfbaltic.org

EMERGENCY CONTACT INFORMATION/CONSENT FORM

Year: 20_____ - 20 _____

Student Information

Student's Full Name: _____ Date of Birth: _____ Grade: _____

Home Address: _____
Street Number City/State/Zip Country

Home Phone: _____ Cell Phone: _____

Student Email Address: _____

Parent/Guardian Information #1 – First Contact

Name: _____ Relationship: _____

Address (if different from above): _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail: _____

Parent/Guardian Information #2 – Second Contact

Name: _____ Relationship: _____

Address (if different from above): _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

E-Mail: _____

Emergency Contact #1 (In case parents/guardians cannot be reached and are authorized to pick up your child)

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Emergency Contact #2 (In case parents/guardians cannot be reached are and authorized to pick up your child)

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

INTERNATIONAL STUDENTS - Please provide the contact information of an English-speaking individual residing in the United States.

Name: _____ Relationship: _____

Home Address: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

AUTHORIZATION FOR MEDIC AL TREATMENT

In the event of an illness or accident, I hereby authorize Academy of the Holy Family High School to act on my behalf for the student named above in the securing of medical, surgical, and/or dental treatment. In the event of an emergency, I hereby give my permission to the health care provider selected by Academy of the Holy Family High School to hospitalize, secure proper treatment for, and to order injections, anesthesia, or surgery for the student named above. If **such an event occurs, I understand that every effort will be made to contact me as soon as possible.** I certify that I am the parent/guardian or have the legal ability to sign these authorizations on behalf of the student named above. I understand I am responsible for all expenses that the above named student's insurance does not pay.

Parent/Guardian Initial Here: _____ **Date:** _____

HIPPA:

☐ I give Academy of the Holy Family Health Office permission *to obtain/provide/exchange* information with *any* health care provider or health care facility. This includes but is not limited to hospitals, walk-in centers, emergency care centers and individual physicians that my daughter may be sent to for medical or psychological evaluation and treatment. This exchange of information includes staff responsible for the health and well-being of student. I understand that I may withdraw my consent at anytime by providing a written request limiting the exchange of information. The Family Right to Privacy Act will protect information placed in my daughter's school health record.

Print Parent/Guardian Name: _____ **Relationship:** _____

Signature Parent/Guardian: _____ **Date:** _____

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ACADEMY OF THE HOLY FAMILY HEALTH FORM

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Health Aide: Mrs. Patricia C. Penney * E-Mail: ppenney_health@ahfbaltic.org

Emergency Contact Information/Consent Form (Continued)

Student Name: _____ **Date of Birth:** _____ **Grade:** _____

PERMISSION TO IMMUNIZE/PERMISSION TO HAVE A SCHOOL/SPORT PHYSICAL EXAM:

☐ I understand that the State of Connecticut has immunization and school physical regulations that my daughter is *expected and required* to have my daughter immunized with the required vaccines including but not limited to (Td, Tdap, Polio, MMR, Varicella and/or MCV4).

☐ I give my permission/consent for a licensed health care provider to perform a school physical examination (required for entry to school and 3 years thereafter) for my daughter if/as needed.

☐ I give my permission/consent for a licensed health care provider to perform a sport physical examination (required prior to participating in any practice sessions or sporting event and every 13 months) for my daughter if/as needed.

☐ I am aware that I will be responsible for any costs for additional immunizations, a school or sport physical not covered under my daughter's insurance.

Parent/Guardian Initial Here: _____ **Date:** _____

HEALTH INSURANCE INFORMATION - (Remember to send copies of Insurance Cards front and back to school)

Name of Medical/Accident/Prescription Insurance Company _____

Phone (_____) _____

Address of Insurance Company _____

Is Pre-authorization required? ☐ Yes ☐ No Is there a Drug Plan? ☐ Yes ☐ No (If no drug plan, please include Prescription Insurance Information below.

Certificate/Policy numbers (include group number if applicable) _____

Name of Policy Holder: _____ SSN#: _____

Address of Policy Holder: _____

Policy Holders Employer: _____ Policy Holder's Date of Birth: _____/_____/_____

☐ I will be responsible for payment in full. I can contact AHF for details regarding the plan.

Parent/Guardian Initial Here: _____ **Date:** _____

International students will automatically be signed up for health insurance through the school.

All Student-Athletes must have either private accident insurance or purchase accident insurance through AHF.

Physician's Name: _____ **Phone:** (____) _____ _____

Dentist Name: _____ _____ **Phone:** (____) _____

Print Parent/Guardian Name: _____ **Relationship:** _____

Signature Parent/Guardian: _____ **Date:** _____

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Rev. 05/17