



AUTHORIZATION FOR CONSENT TO MEDICAL TREATMENT

Student's Name _____ **Date of Birth** _____

In the event of illness, accident, injury or medical emergency, I, the undersigned, hereby authorize the representatives of the Andover ABC program (includes resident director(s), host parents and board members) to consent, with appropriate medical advice, to emergency treatment for the child listed above. The undersigned further agrees to be responsible for any necessary and reasonable medical expenses associated with such emergency treatment.

Signature of parent or guardian _____ **Date** _____

PRIMARY EMERGENCY CONTACT:

Name _____ Relationship _____

Phone # _____ Alternate Phone # _____

OTHER EMERGENCY CONTACT:

Name _____ Relationship _____

Phone # _____ Alternate Phone # _____

MEDICAL INSURANCE COVERAGE

Commercial Insurance: yes _____ no _____

Insurance Company _____ Policy Holder _____ Number _____

Medicaid yes _____ no _____

(If yes, make sure your child has her card with her)

Is your child on any **prescribed medication**? If yes, what is it? _____

Does your child have any **allergies**? If yes, please list _____

Are there any **other medical issues** that you'd like us to know?