

**AUTHORIZATION AND CONSENT TO PROVIDE EMERGENCY MEDICAL CARE
FOR NON-FAIRHILL SUMMER SCHOOL STUDENTS**

_____ (name of student) is my child. In case of accident, illness, or injury during the school day, school personnel will make every effort to contact parents/guardian to apprise them of the circumstances and seek direction for emergency medical care. In such a case where it is impossible to reach us, I/we hereby authorize Fairhill School and its designated representatives to seek treatment, hospitalization, surgery, securing the services of medical personnel, x-rays and/or medications. I/we hereby assume financial responsibility for these costs.

Hospital Preference: _____
Physician: _____ Phone: _____
Dentist: _____ Phone: _____

My child **IS** **IS NOT** covered by medical insurance.
Insurance Company: _____
Primary Insured: _____

MEDICAL HISTORY: My child **does** **does not** wear contact lenses.
Date of Birth: _____ Date of last tetanus shot: _____
Drug allergies _____
Other allergies _____
Medications taken daily _____
Pertinent health information _____

ADDRESS/PHONE INFORMATION FOR EMERGENCIES:
Father's Name: _____ Wk. Phone: _____ Home Phone: _____
Cell: _____
Mother's Name: _____ Wk Phone: _____ Home Phone: _____
Cell: _____

FIRST AID & MEDICATIONS: (CHECK ONE BOX BELOW)
I am giving my permission for the designated Fairhill School representatives to provide my child with routine first aid. They may also give my child the medications I have circled below or listed below.
 My child **may** take Advil (ibuprofen), Tylenol (acetaminophen), antacids
 My child **may not** take any medication at school unless sent by me.

List any prescription medication & dosage that may need to be given at school.

Signature of Parent/Guardian

Date