

Health form and authorization for treatment

Cushing Academy Admissions Office tel: (978) 827-7300
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 Ashburnham, MA 01430-8000 USA admissions@cushing.org

Required yearly

If the student should sustain an injury or contract an illness or have a reoccurrence of a preexisting injury or illness while attending Cushing Academy, immediate medical attention may be necessary. In such event, the school will, of course, make every effort to inform you of the circumstances. However, in the event that the school is unable to contact you, we ask that you grant permission for treatment.

I/We authorize the Health Center to release medical information to appropriate Health Service Facilities and/or Providers of Health Care to adequately care for our child, and to third party payers in request for information for collection. I/We further consent to the administration of necessary and required immunizations, standing order medications, and administration of prescription medications.

I/We grant permission for my son/daughter to self administer over the counter medication (including but not limited to Tylenol, Motrin etc.) or medications prescribed by a physician (*i.e.*: *antibiotics, analgesic etc.*) after the Health Center has determined the student is capable of self administration. Yes No

At Cushing your son/daughter may receive counseling services. I/We grant permission for my son/daughter to receive and/or participate in counseling services with a counselor or psychiatrist at Cushing Academy as indicated or required. Yes No

Signature of Parent/Guardian: _____ **Date:** _____
MONTH/ DAY/ YEAR

Student's Name: _____ Male Female
FIRST MIDDLE LAST

Date of Birth: _____
MONTH/ DAY/ YEAR

Student's Cell Phone# _____

Does he/she take any medications? Yes No *If yes, the prescribing physician must complete the Physician Order Form - G for each prescription medication. Form may be duplicated if needed.*

Legal guardian(s)

Check which apply: Mother Father Both Other (*if other, attach legal documentation*)

Mother's name: _____
FIRST MIDDLE LAST

Address: _____
STREET CITY STATE COUNTRY

Home Phone: _____ Work Phone: _____ Mobile: _____

Confidential Fax: _____ E-mail: _____

Father's Name: _____
FIRST MIDDLE LAST

Address: _____
STREET CITY STATE COUNTRY

Home Phone: _____ Work Phone: _____ Mobile: _____

Confidential Fax: _____ E-mail: _____

EMERGENCY CONTACT/GUARDIAN (if unable to reach parents)

Name: _____ Phone: _____

PLEASE BE SURE TO SIGN ABOVE