Andover A Better Chance
Authorization For Consent to Medical Treatment

School Year _____

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 _____ Phone# _____

Relationship _____ Alternate Phone # _____

OTHER EMERGENCY CONTACT

Name _____ Phone# _____

Relationship _____ Alternate Phone # _____

MEDICAL INSURANCE COVERAGE

Commercial Insurance yes _____ no _____ (If yes, make sure student has her card with her)

Insurance Company _____ Policy Holder _____
Policy Number _____

Medicaid yes _____ no _____

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? _____
_____