A Better Chance of Andover

AUTHORIZATION FOR CONSENT TO MEDICAL TREATMENT
2017-2018

1. **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 ABC of Andover 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 and Primary Emergency Contact further agrees to be responsible for any necessary and reasonable medical expenses associated with such emergency treatment.

2. **A Better Chance of Andover and Andover High School may offer to the student basic over-the-counter medications (Tylenol/Ibuprofen or similar).**

3. Parent/Guardian Signature: _____Date: _____
   Print Name of Parent/Guardian: _____
   Home Phone _____Cell Phone_____ Relationship _____

4. Student's Doctor Name _____
   Address _____
   Phone _____
   Date of last Annual Exam _____

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

  _____

  _____

- Does your child routinely take **over the counter medication**? If yes, what is it?

  _____

  _____

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

  _____

  _____

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

  _____

  _____

5. Student's Dentist Name _____
   Address _____
   Phone _____
   Date of Last Annual Exam _____