St. Andrew's School
350 Noxontown Road
Middletown, Delaware 19709-8512
Phone 302-285-4240 Fax 302-378-8512
E-mail: healthcenter@standrews-de.org

This form must be completed by the parent or guardian.

STUDENT INFORMATION AND MEDICAL AUTHORIZATION

ALLERGIES: PARENTS/GUARDIANS: PLEASE LIST ALL ALLERGIES BELOW:

IF THE STUDENT IS NOT ALLERGIC TO ANYTHING, PLEASE CHECK THIS BOX. ☐

☐ **MEDICATION ALLERGIES:** _____

☐ **FOOD ALLERGIES:** _____

☐ **SEASONAL ALLERGIES:** _____ ☐ **OTHER ALLERGIES:** _____

STUDENT'S NAME _____ GENDER: MALE ☐ FEMALE ☐
FIRST MIDDLE LAST

GRADUATION YEAR: _____ STUDENT STATUS: ☐ NEW ☐ RETURNING PRESENT AGE: _____ BIRTH DATE: _____

Student resides with: ☐ Both parents ☐ Father ☐ Mother ☐ Other: _____

MOTHER	FATHER
BIRTH DATE	BIRTH DATE
LANGUAGE PREFERENCE (IF NOT ENGLISH)	LANGUAGE PREFERENCE (IF NOT ENGLISH)
ADDRESS	ADDRESS
HOME PHONE	HOME PHONE
BUSINESS PHONE	BUSINESS PHONE
CELL PHONE	CELL PHONE
E-MAIL ADDRESS	E-MAIL ADDRESS

If status is other than "Married," please check all that apply to status of parents:
☐ *Separated* ☐ *Divorced* ☐ *Both parents have custody* ☐ *Only Mother has custody* ☐ *Only Father has custody*

ALTERNATIVE RESPONSIBLE PERSON TO BE REACHED IN CASE OF EMERGENCY IF PARENT/GUARDIAN IS UNAVAILABLE:

NAME _____ RELATIONSHIP TO STUDENT _____

HOME ADDRESS _____

HOME PHONE _____ CELL PHONE _____

E-MAIL ADDRESS _____ BUSINESS PHONE _____

MEDICAL TREATMENT/EMERGENCY TREATMENT RELEASE:

I hereby authorize St. Andrew's School and its agents or representatives to consent on my behalf to any medical or hospital care or treatment (including at locations outside of the United States) to be rendered to the student upon the advice of any licensed physician. I also give my permission to administer whatever anesthetic may be necessary or advisable during medical or surgical procedures rendered pursuant to this authorization. I agree to be responsible for all charges incurred in connection with any medical treatment rendered pursuant to this authorization. Transportation charges may be incurred in regards to delivery of care.

Further, I hereby grant permission to St. Andrew's School to release any health information pertaining to the student to facilitate diagnosis, care, treatment or insurance claims. In addition, I authorize St. Andrew's School to release any information pertaining to the above-named alternative responsible person, as well as the following individuals: _____

and to discuss such information with any of these individuals to the extent necessary to facilitate the student's medical treatment or care.

I give permission for the school nurse and my child's primary care physician _____ to share information relating to these health forms.
Name of Physician

It is understood that this permission is valid as long as the student is enrolled at St. Andrew's School.

I certify that all information submitted on all health forms is factually accurate and honestly presented. (The student may be dismissed if the information you have certified is found to be false.).

➡ **X** _____ _____
Signature of Parent or Guardian Date