



Consent to Treat and Release Form

(Parent or Guardian signature required)

Student Name “Student”

Date of Birth

Parent/Guardian

I give permission to Hillside School and its officials, and to hospitals, health care facilities, physicians and surgeons, and other medical, dental and counseling personnel and their staff to secure and furnish mental, medical and surgical care and treatment in the event of illness or accident involving _____ (hereinafter “student”). I give permission and authorize physicians and surgeons rendering care to student to administer prescribed medications including anesthetics and/or to perform emergency surgery or necessary treatments to safeguard and preserve student’s health and to facilitate the medical or surgical treatment of student. I authorized Hillside School to release all medical information concerning Student known to it to hospitals, health care facilities, physicians and surgeons, and other medical, dental and counseling personnel and their staff providing treatment to Student.

Hillside School may also release any insurance information to the above treatment providers for the completion of a claim for health insurance.

Parent/Guardian

Relationship

Date