

Medical Release and Permission

Wyoming Seminary, 201 N. Sprague Avenue, Kingston, Pa., 18704

Student's Family Name _____ First Name _____ Middle _____

Nickname _____ Sex ____ Birthdate: (mm ____ dd ____ yy ____) Social Security Number ____/____/____

Student's Street Address _____

City _____ State _____ Zip/Country Code _____ Country _____

Student's Phone: Country code (____) City/Area Code (____) _____ Fax # _____

Student's Mobile Phone # _____ Student's e-mail: _____

Father's Name _____ Daytime Telephone: (____) _____

Mother's Name _____ Daytime Telephone: (____) _____

Name of Last School Attended _____

Family Physician _____

Physician's Telephone _____ Fax Number _____

Please list any medication taken regularly with the prescribed dosage _____

Please list any allergies and/or health concerns _____

Allergy injections ____ *yes ____ no * **If injections are to be given at the school health service we must receive a doctor's authorization and schedule.**

Is student covered by Health Insurance? yes ____ no ____ **Please copy front and back of insurance card(s) and attach to this form.**

Name of Insurance Company _____ Telephone _____

Insurance Company Address _____

Person in whose name insurance is issued _____ / _____ / _____
(date of birth) (social security number)

Employer Name _____ Employer Telephone _____ I.D. Number _____

Emergency Contact Person: Name _____ **Relationship to student:** _____

Daytime Telephone: Country code (____) City/Area Code (____) _____

Evening Telephone: Country Code (____) City/Area Code (____) _____

Mobile Telephone: Country Code (____) City/Area Code (____) _____

Parent or Guardian Permission for Medical Treatment:

In the event of a student's serious illness or accident, every reasonable attempt shall be made by Wyoming Seminary, its agents and employees, to inform you immediately. Pennsylvania law requires parental consent to medical treatment of minors. If we are unable to contact you in the event that the minor child/ward requires immediate medical treatment, including x-rays, examinations, anesthesia, laboratory procedures, diagnostic tests, and related medical or surgical services, which are deemed necessary or advisable by any attending physician or surgeon for the relief of the minor child/ward, you, as the parent(s) or guardian(s) agree to allow Wyoming Seminary, its agents and employees, to give our consent and to share medical information with, upon your behalf and upon behalf of the minor child/ward to the attending physician or surgeon or to any hospital in which the minor child/ward is admitted to perform any recommended medical or surgical process or treatment after we, our agents and employees, have been informed specifically of the nature and risks and possible consequences of such operation(s), treatment(s), and procedure(s) and of alternative methods of treating the specific medical condition. Upon this understanding, whatever decision is made by us, our agents and employees, regarding such medical treatment, is affirmed by and consented to by you, and you specifically release Wyoming Seminary from any liability for any claim(s) of damages arising there from at any time from the exercise by Wyoming Seminary of its independent and informed judgment.

Signature of Parent/Guardian of Student

Signature of Parent/Guardian of Student

Date