

Designation of Representative to Consent to Medical and Surgical Care for my Child

Name of Student: _____ Date of Birth: _____

REPRESENTATIVE:

I hereby appoint staff members of Scattergood Friends School as my agent(s) and representative(s) for the purpose of authorizing and consenting to hospital, medical, and surgical care and treatment which in the agent's opinion is necessary for the well-being of my child from August 23, 2008 to May 31, 2009. I empower him or her to act as a legal guardian of my child in making decisions and signing authorizations regarding medical and surgical care for my child during the above time period.

I accept responsibility for all costs related to such treatment.

NOTIFICATION:

- _____ Scattergood Friends School should contact me about any medical appointments scheduled for my child. The school has my permission to contact me after the appointment in the case of emergency.
- _____ Scattergood Friends School should contact me only in the event of an emergency. The school has my permission to contact me after the appointment in this case.

EXCEPTIONS: Please list any medical procedures you **DO NOT** want performed on your child:

EMERGENCY CONTACTS:

Please list the names (*in order of priority*) and phones numbers of contacts we should try to reach in case of emergency.

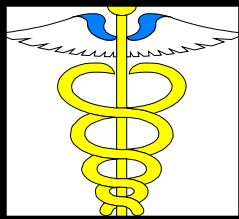
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|----|-------------------|---------------------------------|-------|
| 1. | _____ | _____ | _____ |
| | Name/Relationship | Location (ie: home or business) | Phone |
| 2. | _____ | _____ | _____ |
| | Name/Relationship | Location (ie: home or business) | Phone |
| 3. | _____ | _____ | _____ |
| | Name/Relationship | Location (ie: home or business) | Phone |

AUTHORIZATION SIGNATURES:

I agree to the above designation of representation of my child while at Scattergood Friends School.

_____	_____	_____
Print name of parent or guardian	Signature	Date
_____	_____	_____
Print name of parent or guardian	Signature	Date

PLEASE COMPLETE REVERSE SIDE



HEALTH INSURANCE

It is very important for Scattergood Friends School to have insurance information for your child. Please complete this form carefully.

Name of Student: _____ Date of Birth: _____

My son/daughter is not currently covered by health insurance in the United States. I will make Arrangements to provide health insurance coverage for my child for the academic year. I understand that I am responsible for all costs of medical treatment for my child. Insurance information is available from Scattergood Friends School. (Please sign below as "Policy Holder")

My son/daughter is covered by the healthcare plan described below. I understand that I am responsible for all costs of medical treatment if my insurance carrier denies payment.

INSURANCE INFORMATION:

Name of Insurance Carrier: _____

Name & Address of Policy Holder: _____
(Name) (Address)

(City) (State) (Zip) (Home Phone)

Policy Holder's SS#: _____ Date of Birth: _____

Policy Number and/or Group Number: _____

Claims Mailing Address: _____

Insurance Carrier's Phone Number: _____

I authorize my insurance carrier to issue payment directly to my child's healthcare provider.

Policy Holder's Signature Date

I *do not* authorize my insurance carrier to issue payment directly to my child's healthcare provider. I will pay for the cost of treatment after each visit and should, therefore, be reimbursed directly by my insurance carrier.

Policy Holder's Signature Date

PLEASE COMPLETE REVERSE SIDE