SPAULDING
ACADEMY & FAMILY SERVICES
1871 Celebrating 150 Years 2021

HEALTH SERVICES DEPARTMENT- MEDICAL SERVICES PERMIT

I, _____ parent/guardian, of _____ hereby give my authorization to any medical, surgical or dental care, also to include annual physical and bi-annual dental exams which Spaulding Academy & Family Services, on the advice of a licensed Nurse Practitioner, Physician or Dentist, recommends for my student. I understand that I will be consulted concerning any further recommended care prior to it taking place. In addition, I hereby give my authorization for Spaulding Academy & Family Services to engage with any provider for the following medical services for my student on an as needed basis, to include, but not limited to the following:

Allergist, Audiology, Blood Draws*, Dental, EEG, EKG*, Endocrinology, Gastroenterology, MRI, Neurology, Ophthalmology/Optometry, Orthopedics, Podiatry, Pulmonology, X-ray/scan

Whenever one of the above listed departments/tests are utilized, except those with an *, the results of the test will be reported via correspondence to the student's parent/guardian. For those with a *, only abnormalities will be regularly reported to the parent/guardian via correspondence.

In the event of an emergency, I hereby authorize any medical or surgical care which Spaulding Academy & Family Services, on advice of a licensed Nurse Practitioner, Physician or Dentist, recommends for my student. Consent for the emergency care will be given by a Spaulding Employee through consultation with the Spaulding Resource Staff. I also authorize any anesthesia necessary for the emergency medical or surgical care. It is understood that the above includes, if necessary, any emergency operation or placement in a hospital. I further understand that Spaulding personnel will contact me at the earliest possible moment to inform me of the emergency.

Authorization:

_____ _____
Signature of Mother/Guardian Date

_____ _____
Signature of Father/Guardian Date

_____ _____
Witness Date