SAINT THOMAS MORE SCHOOL HEALTH OFFICE FORM

STUDENT NAME:_____Date of Birth_____

PERMISSION TO OBTAIN MEDICAL TREATMENT:
I hereby authorize and grant to the staff of St. Thomas More School permission to administer/obtain medical care and treatment for my son. When necessary, the staff at the school may seek and obtain medical treatment for my son on an emergent or as needed basis at a licensed hospital and/or with a licensed physician.

HIPPA:
I give Saint Thomas More School Health Office nurse(s) permission to *freely obtain/provide/exchange* information with *any* health care provider or health care facility. This includes but is not limited to hospitals, walk in centers, emergent care centers and individual physicians that my son is sent to for medical/ psychological evaluation and treatment. This may also include exchange of information between the STM nurse and my/my son's insurance company. I understand that I may withdraw my consent at anytime by providing a written request limiting the exchange of information. Any information placed in my son's school health record will be protected by the Family Right to Privacy Act.

PERMISSION TO IMMUNIZE/PERMISSION TO HAVE A PHYSICAL EXAM:
I understand that the State of CT has immunization regulations that my son is *expected and required* to comply with. I am giving STM nurses permission to have my son immunized in accordance with the CT State regulations. I also understand that my son is required by STM to have a current physical exam done every year in order to participate in school activities. I give STM Health Office permission to have a physical exam done on my son if/as needed. I am responsible for any costs not covered under insurance.

HEALTH INSURANCE INFORMATION:
I understand that health insurance is *required* in order for my son to attend STM. *If I do not provide a current insurance card that covers health care services in the USA*, my son will *automatically* be signed up for health insurance through the school. I will be responsible for payment in full. I can contact STM for details regarding the plan.

FLU VACCINATION:
I understand that unless I place a "yes" in the space provided, my son will *not* get a flu vaccine at STM. *If I do place a "yes" in the space provided*, I am confirming that my son is not allergic to eggs, he has never had a serious reaction to a flu shot, and he has never had Guillain-Barre Syndrome. I understand that I may contact the STM Health Office at anytime for more information regarding the flu vaccine. Place "yes" here:_____ .

I have read and understand the above information completely.

PARENT/GUARDIAN SIGNATURE:_____DATE:_____

PLEASE SIGN AND RETURN TO ST. THOMAS MORE HEALTH OFFICE