A Better Chance of Andover

AUTHORIZATION FOR CONSENT TO MEDICAL TREATMENT
2024-25

1. **Scholar's Name** _____ **Date of Birth** _____

   In the event of illness, accident, injury or medical emergency, I, the undersigned, hereby authorize the representatives of the ABC of Andover program **(includes Resident Director(s) and the Health and Wellness Coordinator, occasionally Host Parents and Board Members**) to consent, with appropriate medical advice, to emergency treatment for the child listed above. The undersigned and Primary Emergency Contact further agrees to be responsible for any necessary and reasonable medical expenses associated with such emergency treatment.

2. **All copays for routine and emergency care are the responsibility of the parent/guardian.**
   Agreed ❑

3. A Better Chance of Andover and Andover High School may offer the Scholar basic **over-the-counter medications** (Tylenol/Ibuprofen, cough/cold, antacids, or similar). I give my permission:

   Allowed ❑

4. **A Better Chance of Andover requests that your daughter receives a flu shot each year and it is mandated by the Andover High School.** If your daughter does not obtain a flu shot, all costs for her care will be assumed by the Parent/Guardian. Scholars live in a dormitory environment and their health is a primary concern. **The Scholars will get their shots in Andover when the up-to-date shots are available in the fall, coordinated by the ABC Health and Wellness Coordinator.** I give my permission:

   Allowed ❑

5. Parent/Guardian Signature: _____Date: _____

   Print Name of Parent/Guardian: _____

   Home Phone _____Cell Phone_____ Relationship _____

6. Scholar's Doctor Name _____

   Address _____

   Phone _____

   Date of last Annual Physical Exam (within 1 year) _____

   Date of last immunization update _____

   - Is your child on any **prescribed medication**? If yes, what is it?

     _____

- Does your child routinely take **over the counter medication**? If yes, what is it?

  _____

  Please provide and re-stock prescribed and over-the-counter medications for your daughter at the start of school, during holiday breaks, sending to Andover, or by mail order.

  Agreed ❑
- Does your child have any **allergies**? If yes, please list

  _____
- Are there any other **medical or psychiatric issues** that you'd like us to know about?

  _____
- Is your daughter receiving any **health or behavioral health routine care (regular visits)?**

  _____
- Has your daughter received **COVID vaccinations**? ❑ ***Provide a copy of the vaccination card.***

  _____
- Does your daughter know how to **swim**? _____

7. Scholar's Dentist Name _____

Address _____

Phone _____

Date of Last Annual Dental Exam _____

8. Does your daughter use assistive hearing or other devices? Circle: YES / NO

9. Does your daughter use eyeglasses or contact lenses? Circle: YES / NO

Scholar's Ophthalmologist / Eyecare Center Name _____

Address _____

Phone _____

Date of Last Annual Eye Exam _____

❑ **Provide a copy of the most recent eyeglasses or contact lens prescription.**

Parent/Guardian Signature: _____ Date _____