Greenwich Public Schools
School Health Program
Permission for Treatment (Pre K – 8)

STUDENT NAME _____ **SCHOOL** _____ **GRADE**____
PARENT/GUARDIAN NAME _____ **TELEPHONE** _____

Parent/Guardian Permission for Treatment

Authorization For Medical Care:
In the event of a medical emergency or illness, I hereby authorize Greenwich Public Schools to provide first aid, and/or to request emergency medical treatment and transportation to a hospital. Any hospital or emergency medical personnel are authorized to provide treatment to my child of such nature as they deem appropriate and to consult with the physician listed in the Student Profile.

Parent/Guardian Signature_____**Date**_____

** A child without a history of a severe allergic reaction may receive epinephrine from a certified teacher if a reaction is suspected (CT. Act 14-176). Please contact the nurse directly, if you do NOT wish your child to be included under this law.

Student's Doctor: _____ **Student's Dentist:** _____

Telephone #:_____ Telephone #:_____

Preferred Hospital :_____

Emergency Contact(s) [**other than parents/guardian]: _____

STUDENT HEALTH INSURANCE INFORMATION

Does your child have Health Insurance?_☐_Yes _☐_No

If your child is uninsured we will provide you information on Connecticut's HUSKY Plan. Your signature means that the school can provide you contact information for the Connecticut Department of Social Service (administrating agency of the HUSKY Plan) or information about how to enroll in HUSKY.

_____ _____

Parent/Guardian Signature Date