Authorization to Share Protected Health Information
And
Consent to Emergency Health Care

I authorize the following persons to receive information pertaining to my child's medical condition, health information, medications, and other health-related information:

√ The Bolles School's Director of Health Services
√ Any other person that The Bolles School reasonably determines should have access to my child's health information

I also authorize The Bolles School to obtain such professional medical/surgical care or hospital services as may appear to be necessary or desirable for the protection of the health or life of my child. I authorize The Bolles School to administer emergency care or treatment as required, until emergency medical assistance arrives.

In addition, I authorize The Bolles School to provide to any healthcare provider with my child's medical/health information. Any person rendering health care pursuant to this authorization shall be entitled to treat this consent as having been given by me to such person. I further agree to pay and to hold The Bolles School harmless for any reasonable medical, dental, hospital, or other related charges incurred on behalf of my child.

This Authorization and Consent remains in effect from the date of my child's enrollment through graduation or withdrawal and/or separation from the school, unless otherwise notified in writing.

Child's Name

Parent or Legal Guardian Name (Please print)

Parent or Legal Guardian Signature Date

Director of Health Services, (904) 256-5107