EXHIBIT C

Avon Old Farms School Medical Consent

2014-2015 School Year

New Student ☐ Returning Student ☐ Day Student ☐ Boarding Student ☐

Student Name ____ Date of Birth____/_____/_____
First Last mm dd yy

We the legal parents/guardian of the above named student, hereby authorize the Avon Old Farms School Health Center including without limitation, the school Doctor, staff of the Health Center or athletic trainers, to administer to our child, any health care deemed advisable by a Medical Doctor or Dentist licensed by the State of Connecticut or any other qualified health care professional under the general supervision of a physician. The Health Center has our permission to dispense any over the counter medications for the student to take as directed.

In the event of an emergency, we consent to the immediate transfer of our son to any hospital or appropriate health care facility. We authorize a representative of the Health Center to consent on our behalf to any emergency medical or dental treatment to be rendered to our son and to release pertinent information to appropriate Health Care professionals. All reasonable attempts to contact us in advance of such emergency or other non-routine treatment will be made, provided medical circumstances permit. We also authorize the release of information by any off-campus health care provider to the Avon Old Farms School Health Center.

This consent may be used for any off campus health emergencies. In such cases, the Senior School representative present shall be deemed a representative of the Health Center for the purpose of authorization and consent. We agree that we are exclusively responsible for the payment of all medical and dental services rendered to our son other than routine services provided directly by the School's Health Center. Any copy of this consent shall have the same force as the original.

COMPLETE ALL INFORMATION

Father's name Print		Signature		Date / /
Mother's name Print		Signature		Date / /
Street Address	City	State	Zip Code	Country
Father's Cell #		Student's Cell #		
Mother Cell #		Home Tel #		
Parent E-mail Address				
FOOD/DRUG ALLERGIES				
CURRENT MEDICATIONS				

HEALTH INSURANCE ***Please include front/back copy of insurance card**

Insurance Company Name		Referral Needed? YES_____ NO______
Group #	Identification #	
Insurance Address		Tel #
Subscriber Name	Relationship to Student	
Subscriber's Date of Birth	Subscriber's Social Security #	
Employer		
Prescription Insurance (if different)		
I will be purchasing the Student Insurance Plan at Avon Old Farms School. YES_____ NO______ ***If "YES" please complete the enrollment form and return to the Business Office for billing**		

******While it is the School's ethical responsibility to respect and maintain patient confidentiality, we have the need/ability to share pertinent information on a "need to know" basis to promote the health and safety of an individual student.***