Medical Authorization and Release

If the student designated below should sustain an injury or contract an illness while attending The Blue Ridge School, immediate medical attention may be necessary. In such an event, The Blue Ridge School will, of course, make every effort to inform you of the circumstances and to obtain your instructions regarding medical care. However, to eliminate the possibility of harmful delay arising from an uncertainty as to The Blue Ridge School's authority to arrange for medical treatment for the student, we ask the student's parent or guardian to execute this Medical Authorization and Release.

To: The Blue Ridge School
St. George, VA

Re: _____
(Student's Name – Please Print)

_____
(Date of Birth)

_____
(Social Security Number)

I/We hereby authorize The Blue Ridge School, in the event of an acute medical problem affecting the student designated above, to arrange to have appropriate medical care provided to the student, including, but not limited to, diagnostic and therapeutic procedures performed by a qualified surgeon or other physician and the administration of anesthesia by a qualified anesthetist, if further delay might jeopardize the student's health.

This authorization shall remain in effect for as long as the student is enrolled at The Blue Ridge School, unless earlier revoked by me/us in writing.

I/We understand and agree that I/we shall be financially responsible for all costs and expenses connected with the provision of medical care to the student pursuant to this Authorization, to the extent such costs and expenses are not covered by any applicable insurance policies.

I/We hereby release The Blue Ridge School, its agents, and its employs from any and all claims, demands, actions, and judgments that I/we or anyone claiming through or under me/us may have against The Blue Ridge School in connection with any medical care provided to the student pursuant to this Authorization.

I/We hereby authorize The Blue Ridge School infirmary staff to inform or release medical information to faculty, staff, or other health care providers. This will be done in a confidential manner and only when deemed medically necessary.

_____ _____
Signature of Witness Date Signature of Father or Guardian Date

_____ _____
Name – Please Print Name – Please print

_____ _____
Signature of Witness Date Signature of Mother or Guardian Date

_____ _____
Name – Please Print Name – Please Print