



ROCK POINT SCHOOL

ONE ROCK POINT ROAD
BURLINGTON, VERMONT 05408

Student Name _____ Date of Birth _____

Rock Point School Medical Release to Treat

It is Rock Point School’s policy to make every effort to contact parents/guardians before making an appointment or seeking any medical or dental treatment for any student. This consent form applies in case of emergency or when we are unable to reach parents/guardians within a reasonable period of time.

I hereby give consent for my child/ward named above to receive preventative care and be treated by a physician or dentist for illness or emergency as deemed necessary by the staff of Rock Point School. This includes permission to administer medications, anesthesia, immunizations, and preform minor surgical procedures. I understand that I am responsible for all expenses incurred.

Parent/Guardian Signature _____ Date _____

I hereby give consent for the staff of Rock Point School to give medication to my child/ward as necessary. This includes over-the-counter medications (Tylenol, Sudafed, etc.) and any medication(s) prescribed for my child by a physician.

Parent/Guardian Signature _____ Date _____

Health Insurance Information: (Please supply the school with front and back copies of all insurance cards including medical, prescription, and dental)

Company Name _____ Phone # _____

Company Address _____

Policy Holders Name _____ D.O.B. _____

Policy Number _____ Group Number _____

Plan Code _____ BIN # _____

Company Name _____ Phone # _____

Company Address _____

Policy Holders Name _____ D.O.B. _____

Policy Number _____ Group Number _____

Plan Code _____ BIN # _____

Does your child have any allergies _____ yes _____ no, if yes, please list on back of sheet.

PHONE 802 863-1104

FAX 863-6628

www.rockpointschool.org