

A completed [Release of Claims & Medical Authorization](#) and [Medical Form](#) is required for all **Academic** and **Residence** students for school-year 2011-2012. These forms and all information is needed when seeking medical treatment for a student. Forms are stored and used according to the Medical Form Statement of Privacy.

Medical Form Statement of Privacy - The Rock School takes great care in protecting medical information of all students. Student medical forms are securely stored at The School, only made available to authorized staff members, on a need to know basis. Medical forms are made available to medical authorities in case of emergency per The School's Release of Claims and Medical Authorization Form. Academic and Residence students' medical information will be shared with medical authorities, as deemed appropriate within the scope of The School's Care Waiver. All medical forms for the 2011-2012 school-year session will be shredded and destroyed upon the close of the session. The School will not retain any obsolete student medical information or files.

PLEASE COMPLETE THE BELOW [Release of Claims & Medical Authorization](#) AND [Medical Form](#) AND RETURN TO THE SCHOOL BY EMAIL, MAIL OR FAX. | ATTN: REGISTRATION
1101 South Broad Street | Philadelphia, PA 19147 | (f) 215-551-8538 | star@therockschool.org

Release of Claims & Medical Authorization

ALL INFORMATION MUST BE PLAINLY PRINTED OR TYPED. FORMS MUST BE COMPLETED IN ITS ENTIRETY.

FORMS COMPLETED BY PARENT/GUARDIAN ON BEHALF OF STUDENT:

Student's Name: _____ Date of Birth: ____ / ____ / ____ Circle: Residence | Academics
Home Address: _____ City: _____ State: _____ Zip: _____
Allergies: _____ Other Medical Conditions: _____
Student's Primary Physician: _____ Phone: () _____ - _____

EMERGENCY INFORMATION

Father's Name: _____ Mother's Name: _____
Father's Home Phone: () _____ - _____ Mother's Home Phone: () _____ - _____
Father's Work Phone: () _____ - _____ Mother's Work Phone: () _____ - _____
Father's Cell Phone: () _____ - _____ Mother's Cell Phone: () _____ - _____
Father's E-mail: _____ Mother's E-mail: _____

In the event of an emergency, when parents cannot be reached, please contact:

Name: _____ Home Phone: () _____ - _____ Work Phone: () _____ - _____
Name: _____ Home Phone: () _____ - _____ Work Phone: () _____ - _____

INSURANCE INFORMATION [PLEASE COPY BOTH SIDES OF YOUR MEDICAL INSURANCE CARD onto a 1 page and attach to this completed form.](#)

Health insurance is mandatory for all Rock School students. The School will not be responsible for any medical expenses incurred for treatment of any student. If you are a citizen of the United States, please contact your local insurance carrier and confirm that your child will be covered in Pennsylvania and obtain the necessary information for the provider they must visit to ensure coverage. International student may refer to the **Independent School Management, Inc. Information Sheet**, for information about acquiring health insurance coverage.

Name of Insurance Carrier: _____ Telephone Number: () _____ - _____
Address of Insurance Carrier: _____
Policy Identification Number: _____ Group Number: _____
Subscriber's Full Name: _____ Relation to Student: _____



STUDENT MEDICAL REPORT - To be completed by primary health care provider.

Physical Examination - DATE OF PHYSICAL MUST BE 2011

Date of Physical examination ____ / ____ / 2011

Height _____ Weight _____ Pulse _____ Blood Pressure _____

Immunization & Testing Records

Date of student's last tetanus immunization was ____ / ____ / ____

List any drugs or food which the student is allergic to:

Does the student have any health problems that required periodic evaluation or testing? Yes No (details)

List any other health or personal concerns that The Rock School should be aware of in regard to the student:

Student is physically fit to attend The Rock School's 2011-2012 school-year programs? Yes No(details)

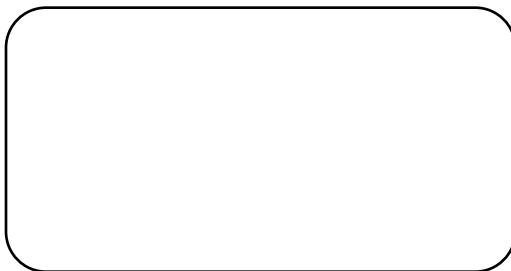
Physician's Name (printed):

Telephone Number

Physician's Office Address

Physician's Signature

Date



PHYSICIAN'S STAMP | MANDATORY

