Valley School District No. 070
3030 Huffman Road • Valley, WA 99181 • Ph: (509) 937-2791 • Fax: (509) 937-2691 • www.valleysd.org

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

School Year: 20___ / 20___

This form grants temporary authority to designated adult staff of Valley School District to provide and arrange for medical care for a minor (un-emancipated child under the age of 18) in the event of an emergency, where the minor student is not accompanied by either parents or legal guardians and it may not be feasible or practical to contact them. A copy of this form should be carried and/or readily available by the designated adult staff to present to medical personnel.

Minor/Student Name _____ Birthdate _____

Address _____

Parent/Guardian Name _____ Phone _____

Parent/Guardian Name _____ Phone _____

Medical Information

Family Physician / Clinic _____

Address _____ Phone _____

Insurer/Health Plan Provider _____ Policy Number _____

Allergies to Medications _____

Other Allergies _____

Note all serious health conditions for which the child is currently receiving treatment _____

_____

Note any other significant medical information _____

_____

Authorization and Consent of Parent(s) or Legal Guardian(s)

I hereby state that I have legal custody of the aforementioned minor child (hereafter "student"). I grant my authorization and consent for the designated adult Valley School District staff person(s) (hereafter "designated staff") into whose care the student has been entrusted to administer general first aid treatment for any injuries experienced by the student.

If the injury is life-threatening and/or poses a serious health risk to the student, I authorize the designated staff to summon any and all professional emergency personnel to attend, transport and treat the student and to issue consent for any X-ray, anesthetic, blood transfusion, medication or other medical diagnosis, treatment or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care.

I understand that in the event emergency medical treatment is necessary, designated staff will make a reasonable attempt to contact me before relying on this authorization. I understand this authorization is given in advance of any such emergency medical treatment, but is given to provide authority and power on the part of the designated staff in the exercise of his/her best judgment upon the advice of any such medical or emergency personnel. This authorization is effective through the current school term.

Signature of Parent/Guardian: _____ *Date:* _____

Name of Parent/Guardian (please print): _____

Signature of Parent/Guardian: _____ *Date:* _____

Name of Parent/Guardian (please print): _____