VALLEY VIEW SCHOOL DISTRICT
EMERGENCY MEDICAL AUTHORIZATION

Enrolled at: ___Primary School ___ Intermediate School ___Junior High School ___High School

Student's Name _____ Phone _____
First Middle Last

Mailing Address _____ Apt. No. _____ Grade _____

City_____Zip Code_____ Birth Date _____ Gender_____

Purpose- To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian (List in order of contact) ☐ **Please check this box if the above address is different from last school year**

1st _____ _____ _____ _____ _____
Name Home/Work Cell Phone Pager Relationship

2nd _____ _____ _____ _____ _____
Name Home/Work Cell Phone Pager Relationship

3rd _____ _____ _____ _____ _____
Name Home/Work Cell Phone Pager Relationship

Name of Relative or Childcare Provider

_____ _____ _____ _____ _____
Name Home/Work Cell Phone Pager Relationship

Address _____ Apt. No. _____ City _____

Part I or II Must Be Completed

Part I – To Grant Consent

I hereby give consent for transportation and treatment by the following medical care providers and local hospital:

Doctor _____ Phone _____
Dentist _____ Phone _____
Hospital_____Phone _____

The authorization does not cover major surgery unless the medical opinions of 2 other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before the surgery is performed.

*Any health or physical problems?	_____Yes _____No
*Any respiratory problems?	_____Yes _____No
*Any Diabetes, Epilepsy, or other chronic diseases?	_____Yes _____No
*Any allergies to food or medication?	_____Yes _____No
*Any speech, hearing, or vision problems?	_____Yes _____No
*Any regular medications?	_____Yes _____No

If any of the above are marked "YES", please explain or give any facts concerning the child's medical history including allergies, medications being taken and any physical impairments to which a physician should be alerted.

_____
_____
_____
_____

_____ _____ _____
Date Signature of Parent/Guardian Address

DO <u>NOT</u> COMPLETE PART II IF YOU COMPLETED PART I.

PART II (REFUSAL TO CONSENT)

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:

_____ _____ _____
Date Signature of Parent/Guardian Address