

**RE: Emergency medical treatment for \_\_\_\_\_**

TO WHOM IT MAY CONCERN:

I, \_\_\_\_\_, custodial parent or legal guardian of the above named student, whose date of birth is \_\_\_\_\_, hereby give permission to any emergency medical technician, nurse, ophthalmologist, physician or physician's assistant, to treat my child for any illness, trauma, accident, or medical emergency s/he may experience while attending school at *DOUBLE ADOBE SCHOOL* or while traveling with her/his class on field trips during the 2014-2015 school year. I also authorize the *TEACHER* to make medical decisions regarding my child in my absence. I understand that all attempts will be made to notify me of my child's medical condition and decisions which have been made as soon as is reasonably possible, but that treatment will not be delayed for that reason. I agree that I will be financially responsible for the emergency medical treatment incurred.

My child:

- Is not allergic to any medications and has no other allergies.*
- Has the following allergies:*

\_\_\_\_\_

- Is taking the following medications:*

\_\_\_\_\_

My medical insurance is: \_\_\_\_\_

My policy number and/or group coverage number is: \_\_\_\_\_

Dated this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Street address

\_\_\_\_\_  
Mailing address

\_\_\_\_\_  
City, State, Zip Code

Telephone numbers at which I may be reached: \_\_\_\_\_ (H); \_\_\_\_\_ (W);  
\_\_\_\_\_ (C).

In the alternative, you may reach \_\_\_\_\_, at the following telephone numbers: \_\_\_\_\_ (H); \_\_\_\_\_ (W); \_\_\_\_\_ (C).