

Student Name: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

**AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**

As legal custodian of \_\_\_\_\_, I hereby authorize the principal or his/her designee, into whose care the aforementioned minor pupil has been entrusted to consent to an X-ray, examination, anesthetic, medical or surgical diagnosis, treatment, and/or hospital care to be rendered to said minor upon the advice of any licensed physician and/or dentist.

I understand that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides authority and power to the aforementioned agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which a licensed physician or dentist may deem necessary.

This authorization shall remain effective for the full school year unless revoked in writing and delivered to said agent(s). I understand that the Millbrae School District, its employees and its Board assume no liability of any nature in relation to the transportation or treatment of the said minor. I further understand that all costs of paramedic transportation, hospitalization, and any examination, X-ray, or treatment provided in relation to this authorization shall be my responsibility.

I understand that the Millbrae School District does not provide accident medical insurance for students for school related injuries but does offer student accident insurance for voluntary purchase. I have received the information and application for this program.

**Please check one of the following:**

- I am enrolling my child in the student health insurance program. I understand a fee is required.
- I am NOT enrolling my child in the student health insurance program.

Family Doctor: \_\_\_\_\_ Address: \_\_\_\_\_ Phone # \_\_\_\_\_

Health Plan/Insurance (i.e., Blue Cross, Kaiser, etc.): \_\_\_\_\_ Group Policy # \_\_\_\_\_

My child is allergic to the following medication(s): \_\_\_\_\_

\_\_\_\_\_

Other medications used: \_\_\_\_\_

My child has the following health problems: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please sign and date below:**

SIGNATURE OF PARENT/GUARDIAN: \_\_\_\_\_ DATE: \_\_\_\_\_