Millbrae Elementary School District
555 Richmond Drive
Millbrae, CA 94030
650-697-5693 ● 650-697-6865 (fax) ● www.millbraeschooldistrict.org

2024-2025

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT/EMERGENCY RELEASE INFORMATION

Student Name (Please Print)	Grade	School
Address	City, State, Zip	Phone

As legal custodian of (student name aforementioned above), 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 Elementary 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 Elementary School District does not provide accident medical insurance for students for school-related injuries but does offer student accident insurance for voluntary purchase.

Parent Guardian Name (Please print)

X

Parent Guardian Signature

Date

PLEASE COMPLETE THE FOLLOWING:

Family Doctor:	
Address:	
Phone #	
Health Plan/Insurance Carrier	
Group Policy #	
My child is allergic to the following medications:	
Other medications used:	
My child has the following health problems:	
Explanation or comments about medical conditions that the school should be aware of:	

*******PLEASE NOTE*******

If it is necessary for your child to take medication at school, you must provide the school with the physician's written instruction **and** your written permission. Medication at school must be kept in the original pharmacy container. No medicine of any kind (prescriptions or non-prescription drugs including aspirin or aspirin substitutes) will be given at school unless the above conditions are met. Please notify the school each time there is a change in any of this information. Please visit the Health Services page on our website for forms.

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PARENT INFORMATION

With whom does the student live? (Please check)	☐ Parents	☐ Mother	☐ Father	☐ Shared Custody	☐ Guardian

PARENT/GUARDIAN #1: (PLEASE PRINT)	**PARENT/GUARDIAN #2: (PLEASE PRINT)**
(Please Check) ☐ Mother ☐ Father ☐ Natural ☐ Step-parent ☐ Other	(Please Check) ☐ Mother ☐ Father ☐ Natural ☐ Step-parent ☐ Other
Home Address:	Home Address:
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:
Employer:	Employer:
Work Address:	Work Address:
Occupation:	Occupation:
E-Mail Address:	E-Mail Address:
Education level: (Please check) ☐ High School ☐ Not High School Grad ☐ College Grad ☐ Post Grad School ☐ Decline to answer ☐ Unknown	Education level: (Please Check) ☐ High School ☐ Not High School Grad ☐ College Grad ☐ Post Grad School ☐ Decline to answer ☐ Unknown

PLEASE LIST ALL AUTHORIZED INDIVIDUALS TO WHOM CHILD MAY BE RELEASED (OTHER THAN PARENT/GUARDIAN): *(AT LEAST 2 REQUIRED)*

	Name	Relationship	Home Phone	Cell Phone
1.				
2.				
3.				
4.				

PLEASE LIST ALL OTHER CHILDREN IN HOUSEHOLD

Last Name	First Name	Birth Date	Sex	School