(White Cardstock)

MARY WALKER SCHOOL DISTRICT
AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

As legal custodian of _____, a minor, I hereby authorize the principal or his/her designee, into whose care the aforementioned minor pupil has been entrusted, to consent to any 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 Mary Walker School District, its employees and its Board assume no liability of any nature in relationship 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 Mary Walker School District <u>does not</u> 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 complete other side of this form.)

Student's Name _____ CH-XC-VB-FB-GBB-BBB-WR-SB-BS-TR

PLEASE CHECK: _____ I will enroll my child in the school's student accident insurance.
_____ I will not enroll my child in the program and have completed a waiver.

SIGNATURE OF PARENT OR GUARDIAN: _____ DATE: _____

Home Address: Home & Work Phone Numbers:

Name and Address of Family Doctor:

Health Plan/Insurance (i.e. Blue Cross, MSC, etc.) Group/Policy No:

My child is allergic to the following medications:

Other medications used:

My child has the following health problems:

Signature of Parent or Guardian: Date: