AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT
SUGGESTED LANGUAGE

Dear School Administrator:

Schools commonly seek updated "Emergency" information from parents on an annual basis. The "Authorization for Emergency Medical Treatment" language shown on the reverse side of this form includes reference to financial responsibility, availability of insurance and a waiver of same. It (or similar language) is currently used by many schools and school districts for the following reasons:

- To clarify for parents school policy regarding medical emergencies;
- To obtain preauthorization from parents to seek treatment in the event their child is injured during a school activity;
- To make clear to parents that the school does not accept responsibility for medical bills in the event of an injury to their child;
- To document notification to parents that voluntary purchase student accident insurance is made available.

Use of this emergency card approach may help strengthen the school's position should a student be injured during a school activity as well reduce the likelihood of uninsured student injuries and related litigation.

We recommend that you seriously consider using the suggested emergency card language for all your students. Should you have any questions, please call our office at (800) 827-4695.

Sincerely,

Myers-Stevens & Toohey Co., Inc.

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 initiate paramedic/ambulance care or transport for said minor and 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 **(ABC School or School District),** its employees and its Board assume no liability of any nature in relation to the transportation or treatment of said minor. I further understand that all cost of paramedic/ambulance transportation, hospitalization, and any examination, X-ray, or treatment provided in relation to this authorization shall be my responsibility.

I understand that the **(ABC School or School District)** does not provide medical insurance for student injuries but does offer student accident/sickness insurance for voluntary purchase. I have received the information and application for this program.

PLEASE CHECK: ☐ I will enroll my child in the program

☐ I will not enroll my child in the program

Signature of parent or guardian: _____ Date: _____

Family Doctor **Address**	**Daytime phone**
Health Plan/Insurance (i.e. Blue Cross, Kaiser, 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:**