

Student's Name: _____ Birthdate: _____ Grade: _____ Teacher: _____

TRACY UNIFIED SCHOOL DISTRICT EMERGENCY TREATMENT FORM

Note: If the information listed below changes at any time during the school year, notify the office immediately!

The Tracy Unified School District's Emergency Treatment Policy for student injury and illness at school permits school personnel to dial "911", the emergency telephone number. With authorization, emergency medical treatment can be provided. For other than life-sustaining treatment, the medical professionals require the parent/guardians' authorization before emergency treatment can be administered.

In the event of serious injury or illness, school personnel will immediately attempt to notify the parent/guardian. If the parent/guardian cannot be reached, and this form is on file in the school office, the school will be authorized to arrange transportation of the student for emergency medical treatment. This form also authorizes a medical professional on duty to perform emergency treatment.

Please complete this form below and return it immediately to your child's school to be placed on file in the school office. Thank you for your cooperation. **PLEASE PRINT LEGIBLY**

Parent/Guardian's name with whom child is residing: _____

Circle if Parent or Guardian **Check if**
Parent #1/Guardian's Name: _____ Address: _____ **New Address:** _____

Employer Name/address: _____ House # _____ Cell# _____ Work# _____

Parent #2/Guardian's Name: _____ Address: _____ **Check if**
New Address: _____

Employer Name/address: _____ House # _____ Cell# _____ Work# _____

Emergency contact persons by priority, if unable to contact parent/guardian: Please **list LOCAL names**, if possible.

1. Name: _____ Relationship: _____ Phone #: _____ Cell # _____

2. Name: _____ Relationship: _____ Phone #: _____ Cell # _____

3. Name: _____ Relationship: _____ Phone #: _____ Cell # _____

4. Name: _____ Relationship: _____ Phone #: _____ Cell # _____

Does your child have any medical disorders that the school/doctor should be aware of before treatment? Please describe:

Doctor's Name: _____ Phone #: _____

Insurance Company name: _____ Policy #: _____

AUTHORIZATION FOR EMERGENCY TREATMENT AND TRANSPORTATION

I authorize Tracy Unified School District to dial "911" and to arrange emergency transportation to an emergency treatment center or hospital for my child is s/he is seriously injured or ill.

The undersigned has authorized necessary emergency treatment for the patient whose name appears above and that the treatment and procedures will be performed by medical professionals. The undersigned understands that a personal physician is to be selected by, or on behalf of, the patient within 24 hours if hospitalization or further treatment is required, or immediately, if complications arise.

Financial Responsibility: Parents are reminded that financial responsibility including all costs of paramedic, transportation, hospitalization, and any examination, treatment, or x-ray provided shall be the parent/guardian's responsibility should emergency treatment become necessary.

The undersigned has read the above authorization and understands the same and certifies that no guarantee or assurance has been made as to the result that may be obtained. This authorization for emergency treatment and transportation will remain in effect during the time the student is enrolled in a Tracy Unified School District School or program. Authorization is also hereby granted for release to all insurance companies and agencies such information as may be necessary for completion of hospitalization claims.

Parent/Guardian Signature: _____ **Date:** _____