



**AUTHORIZATION FOR EMERGENCY TREATMENT AND TRANSPORTATION**

**Student's Name:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

I authorize Jefferson School District to dial "911" and to arrange emergency transportation to an emergency treatment center or hospital for my child if 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 that the student is enrolled in the Jefferson School District. Authorization is also hereby granted for release to all insurance companies and agencies such information as may be necessary for completion of hospitalization claims.

Does your child have any medical disorders that the school/doctor should be aware of before treatment?  
Yes or No – If yes, please describe below:

\_\_\_\_\_

Medical Insurance Company: \_\_\_\_\_ Group/Policy # \_\_\_\_\_

Primary Physician's Name: \_\_\_\_\_ Physician's Phone #: \_\_\_\_\_

**Print Parent/Guardian Name:** \_\_\_\_\_

**Parent/Guardian's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_