Methow Valley School District
Authorization for Emergency Medical / Dental Treatment

Student name: _____ Date of birth: _____

Parent/guardian: _____ Contact #: _____

Parent/guardian: _____ Contact #: _____

Medical insurance company: _____ Policy #: _____

Dental insurance company: _____ Policy #: _____

❒ My student has no known allergies.

My student is allergic to the following: _____

❒ This student has an **emergency care plan** that should accompany them when leaving school grounds.

I want the medical staff to be aware of the following if a need for emergency treatment occurs:

_____

_____

I authorize the principal or his/her designee to transport and seek emergency medical or dental treatment when the need for such treatment is immediate and when efforts to contact me are unsuccessful. I understand that the Methow Valley School District, its employees and its Board of Directors assume no liability of any nature in relationship to the transportation or treatment of the said minor. I further understand that all costs of EMS transportation, hospitalization, examination, x-ray or treatment provided in relation to this authorization shall be my responsibility. This authorization shall remain effective for the full school year unless revoked in writing and delivered to the Methow Valley School District.

_____ _____

Signature of parent/guardian **Date**