SIMI VALLEY UNIFIED SCHOOL DISTRICT
AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

DATE: ____/____/____ STUDENT ID: _____ SCHOOL: _____

School authorities will notify you or your designated representative if your child is ill or injured. If no one can be reached, it is the policy of the Board of Education to obtain transportation (which may require an ambulance) to the nearest emergency hospital unless your instructions to the contrary are on file at the school.

The undersigned who is (check one box) ☐ a parent having legal custody ☐ the legal guardian of

_____, a minor, hereby authorizes Simi Valley Unified School District staff, the person(s) into whose care aforementioned minor pupil has been entrusted, to consent to any emergency treatment, including but not limited to X-ray examination, anesthetic, medical or surgical diagnosis, treatment and/or hospital care to be rendered to said minor under the supervision and upon the advice of any physician licensed by the State of California; or to consent to any X-ray examination, anesthetic, dental surgical diagnosis or treatment and/or hospital care to be rendered to said minor by any dentist licensed by the State of California.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician or dentist in the exercise of his best judgment may deem advisable.

This authorization shall remain effective for the full school year unless revoked in writing and delivered to said agent(s).

I understand that the Simi Valley Unified School District, its officers and employees assume no liability of any nature whatsoever in relation to any emergency medical treatment or transportation of: _____

I further understand that all costs of ambulance, hospitalization, and any examination, X-ray or treatment provided in relation to this authorization shall be borne by the undersigned.

My child is allergic to the following medications: _____

My child is pre-registered at the following hospital/medical center: _____

_____ _____ _____

Insurance Company Signature of Parent/Guardian Date

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