WELLSPRINGS HIGH SCHOOL

EMERGENCY MEDICAL TREATMENT AUTHORIZATION

I, the undersigned parent or guardian of _____,
(Student's full legal name)

do hereby authorizes staff of Wellsprings High School to transport and seek emergency medical or surgical treatment to this minor student.

Student's Date of Birth _____ Student Preferred Name _____

Parent Name _____ (Cell) Phone _____

Home Address _____

Employer _____ Work Phone _____

Other Emergency Contact _____ Phone _____

Family Physician _____ Phone _____

Health Insurance Co. _____ Group ID _____

Medical conditions _____

Current Medications _____

Allergies, etc: _____

This authorization shall be effective for as long as my student is enrolled at WFS.

Parent Signature _____ Date _____

AN ATTEMPT WILL BE MADE TO NOTIFY PARENTS IMMEDIATELY IN THE EVENT OF AN EMERGENCY, BEFORE TREATMENT IS PROVIDED.