



3590 W. 18th Ave • Eugene, Oregon 97402 • 541-686-1223 • Fax 541-687-1493

EMERGENCY MEDICAL TREATMENT AUTHORIZATION

The undersigned parent or guardian of _____
(Student's full legal name) (Preferred Name)

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

Student's Date of Birth _____

Parent/Guardian Name _____ Phone _____

Home Address _____

Employer _____ Work Phone _____

Other Emergency Contact _____ Phone _____

Family Physician _____ Phone _____

Health Insurance Co. _____ Group ID _____

Medical conditions _____

Current Medications _____

Allergies _____

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

Parent/Guardian Signature _____ **Date** _____

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