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 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 ____

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.