Great Northern School District #312
3115 N. Spotted Rd.
Spokane, WA 99224
Phone: (509) 747-7714
Fax: (509) 838-5670
www.gnsd.k12.wa.us

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Student's Name: _____
Last First Middle

Family Physician: _____ _____
Name Phone

_____
Address

Health Plan or Insurance: _____

My child is *allergic* to these medications and or foods: _____

_____

My child uses the following medication: _____

My child has the following health problems: _____

As the parent or legal guardian of the minor child listed above, I hereby authorize the principal or the designee to consent to any X-ray, examination, anesthetic, medical or surgical diagnosis, treatment, and or hospital care rendered to say minor child upon the advice of any licensed physician and or dentist.

I understand that this authorization is given in advance of any required diagnosis, treatment, or hospital care and provides power and authority to the principal or designee to give specific consent to any and all such diagnosis, treatment, or hospital care which a licensed physician or dentist may deem necessary.

This authorization will remain in effect for the entire school year unless revoked in writing and delivered to the school. I understand that the Great Northern School, its employees, and its Board assume no liability of any nature in relationship to the transportation or treatment of the child. I further understand that all costs of the paramedic transportation, hospitalization, any examination, X-ray, or treatment provided in relation to this authorization will be my responsibility.

Name of Parent and/or Guardian (please print): _____

_____ _____
Signature of Parent and/or Guardian Date

Revised: 8/18/2010