

SLVUSD Charter School
Authorization for Medical Treatment

Name of Student
Participant _____

Parent or Legal Guardian
Name _____
Address _____ City _____ Zip Code _____

Daytime Phone Number _____ Evening Phone Number _____

If no one is available at the above phone numbers in case of an emergency, please contact the following person(s) who are hereby authorized to approve emergency medical treatment during any times in which the Parent or Legal Guardian listed above cannot be reached:

Name	Phone Number	Relation to Minor

Authorization for Emergency Treatment: If I cannot be contacted in the event of an emergency I hereby give permission to the Emergency Contacts listed above and (if they cannot be reached) to the SLVUSD Charter School Staff and other SLVUSD representatives to act for me to consent to X-rays, tests, treatment, anesthetic, medical or surgical diagnosis or treatment, necessary transportation and/or hospitalization for my child (the Student), all for my account and at my expense.

I hereby represent to SLVUSD Charter School that I am the parent or legal guardian of the above-named minor student and that I am authorized to sign this Authorization of Medical Treatment on behalf of both the above-named minor Student ("Student") and his/her parent(s) and/or legal guardian(s) ("Parent(s)/ Guardian(s)").

I have read this Agreement in its entirety. I understand its terms and agree, on behalf of the Student listed above as well as his/her Parent(s)/Guardian(s) to be legally bound by it.

Name of Student (Please Print)

Parent/Guardian Name (Please Print)

Date of Signature by Parent/Guardian

Signature of Parent/Guardian