PENDLETON SCHOOL DISTRICT 16R

Dear Parent/Guardian:

While participating in extracurricular activities, an emergency situation may occur. Pendleton School District 16R is requesting authorization for a coach, teacher or administrator to consent for evaluation and treatment of an illness or injury involving your son or daughter. Such care is to be rendered under the supervision of a licensed physician. This includes treatment at a hospital or medical office, or ambulance service.

This authorization will be used only when the parent/guardian cannot be reached; and shall be renewable each year. If the form is not fully completed the participant will not be able to participate.

AUTHORIZATION FOR ANOTHER TO CONSENT TO TREATMENT OF CHILD

As a parent or legal guardian of the following child:

_____ _____ _____ GRADE: 6 7 8 (Circle)
STUDENT NAME (LAST) (FIRST) (MIDDLE INT.)

I hereby authorize representatives of Pendleton School District 16R to consent to any medical or surgical treatment of the above named child which such person deems advisable, if a parent or legal guardian cannot reasonably be located when the child is brought in for treatment.

This authorization is effective for the school year of _____

_____ _____ _____
PARENT/GUARDIAN ADDRESS HOME PHONE #

_____ _____
EMPLOYER WORK PHONE #

_____ _____
NAME OF OTHER ADULT IF YOU CANNOT BE REACHED EMERGENCY PHONE #

_____ _____
FAMILY PHYSICIAN OFFICE PHONE #

Indicate any known physical problems or allergies we should be aware of: _____

_____

_____

Current medication of above child: _____

Date of last tetnus immunization: _____

PROOF OF INSURANCE COVERAGE

Students will not be able to participate in extracurricular activities without proof of insurance. Please complete one of the two options below:

My son/daughter is covered under the following insurance plan:

_____ _____ _____
INSURANCE COMPANY GROUP # I.D. #

OR

_____ I/We have purchased school insurance: Date of Purchase: _____

I understand I am financially responsible to the hospital for charges not paid by the insurance coverage and I authorize the treating facility to release the necessary medical information requested for insurance purposes. Additionally should my child's care require transfer to another health care facility, I authorize the transferring facility to forward to the receiving facility photocopies of any medical records as are deemed necessary to assist in the continuity of care, including x-rays. I recognize that the information disclosed may contain information that is protected by Federal and State law, and I specifically consent to disclosure of such information.

_____ _____
SIGNATURE RELATIONSHIP

WHITE COPY - COACH YELLOW COPY- AD OFFICE