AMLJIA

ALASKA MUNICIPAL LEAGUE JOINT INSURANCE ASSOCIATION

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

As legal custodian of_____, a minor, I hereby authorize the principal or his/her designee, into whose care the aforementioned minor pupil has been entrusted, to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis, treatment, and/or hospital care to be rendered to said minor 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 authority and power to the aforementioned agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which licensed physician or dentist may deem necessary.

This authorization shall remain effective for the full school year unless revoked in writing and delivered to said agent(s). I understand the _____District, its employees and its Board (1) assume no liability of any nature in relation to the transportation or treatment of said minor, and (2) is not responsible for the medical bills in the event of an injury to my child.

FAMILY DOCTOR	ADDRESS	DAYTIME PHONE
HEALTH PLAN/INSURANCE (I.E. BLUECROSS)		GROUP/POLICY NO.
MY CHILD IS ALLERGIC TO THE FOLLOWING MEDICATIONS:		
OTHER MEDICATIONS BEING USED:		
MY CHILD HAS THE FOLLOWING HEALTH PROBLEMS:		
SIGNATURE OF PARENT OR GUARDIAN:		DATE: