



SAN FERNANDO VALLEY ACADEMY

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CONSENT TO RENDER EMERGENCY MEDICAL TREATMENT 2024-2025 SCHOOL YEAR

I, the undersigned parent or legal guardian, give my consent for first aid and emergency medical treatment to be administered to the child listed below.

It is understood that reasonable effort will be made to contact my child's doctor listed below. It is further understood that this consent is given in advance of any specific diagnosis or treatment which might be required and is given to authorize San Fernando

Valley Academy and/or the physician to exercise their best judgment as to the requirement of such diagnosis or treatment. This authorization is given pursuant to the local state Civil Code.

Should my child need to be transported to a hospital, I understand and accept responsibility for any charges incurred. In the event my child is well enough to return to San Fernando Valley Academy before I am able to arrive at the emergency room, my child may be released into the custody and care of the principal or other designated representative, and returned to San Fernando Valley Academy.

STUDENT'S NAME _____ BIRTHDATE _____

ADDRESS _____

PARENT/GUARDIAN'S NAME _____

PHONE NUMBERS Mother's Cell # _____ Father's Cell # _____

Mother's Work # _____ Father's Work # _____

HOME # _____ OTHER # _____

PHYSICIAN'S NAME _____ TELEPHONE # _____

MEDICAL INSURANCE & ID/POLICY # _____

PREFERRED HOSPITAL _____

MEDICAL HISTORY (I.E., ASTHMA, DIABETES, RECENT SURGERY, CHRONIC ILLNESS, ETC.) _____

ALLERGIES _____

MEDICATIONS CURRENTLY TAKING _____

When my child is on school trips off campus, this consent will also include administering over-the-counter medications (i.e. pain medication, antihistamine, decongestant, cough medicine, etc.) when deemed necessary.

I AM GIVING the names of two relatives or friends who have consented to assume the responsibility of my child in case of illness or accident until I can be reached. In case of any changes in the named persons, I will notify the school in writing.

1. Name _____ Relationship _____ Cell # _____

Address _____

2. Name _____ Relationship _____ Cell # _____

Address _____

WARNING: DO **NOT** GIVE THE FOLLOWING OVER-THE-COUNTER MEDICATIONS TO MY CHILD _____

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

Print NAME _____