SAN FERNANDO VALLEY ACADEMY
17601 LASSEN STREET, NORTHRIDGE, CA 91325
TEL 818-349-1373
FAX 818-773-6353
WWW.SFVA.ORG

CONSENT TO EMERGENCY MEDICAL TREATMENT

2021-2022 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____/____/____ SS# _____-_____-_____

ADDRESS _____

PARENT/GUARDIAN'S NAME _____

PHONE NUMBERS: HOME_____ DAD WORK_____

MOM WORK_____ DAD CELL_____

MOM CELL_____ 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_____

Please give the names of two relatives or friends who have consented to assume the responsibility of your child in case of illness or accident until you can be reached. In case of any changes in the named persons, notify the school in writing.

1. Name _____Phone _____ Cell _____
   Address _____
2. Name _____Phone _____ Cell _____
   Address _____

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.

DO **NOT** GIVE THE FOLLOWING OVER-THE-COUNTER MEDS TO MY CHILD_____

PRINT PARENT/GUARDIAN NAME_____

SIGNATURE OF PARENT/GUARDIAN _____ DATE_____/_____/_____