



SAN FERNANDO VALLEY ACADEMY

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CONSENT TO EMERGENCY MEDICAL TREATMENT 2022-2023 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 _____