WISD Emergency Medical Treatment Form

***** YOU MUST COMPLETE AND RETURN THIS FORM TO YOUR STUDENT'S CAMPUS *****

I hereby authorize the staff member(s) at Waller ISD to consent to emergency medical treatment for:

Student Information

Student's Last Name (Print):	Student's First Name (Print):	Student's Middle Name:
Birth Date (mm/dd/yy):	Grade:	Homeroom Teacher:
School:		Student ID (if known):

In the event of a medical emergency at school, the school will first try to contact the child's parents. If the parent cannot be reached and the child needs immediate medical treatment, the form below would be given to the hospital or clinic. The purpose of the Emergency Medical Treatment Form is to obtain medical treatment for your child in the event you cannot be contacted. I understand in granting this authorization that:

- *My child will be taken to a hospital or clinic nearest to the school or activity he or she is attending so that emergency medical treatment can be obtained.*
- *School staff members will attempt to contact me before consenting to emergency medical treatment for my child.*
- *I will be responsible for all expenses incurred by virtue of the emergency medical treatment of my child and for the transportation to the emergency medical treatment facility.*
- *I release staff members and trustees from any and all claims or actions from liabilities for the injuries that occur to my child as a result of his or her receipt of emergency medical care.*
- *The staff members of Waller ISD, its trustees and agents are not waiving any sovereign or governmental immunity by requesting the execution of this document.*
- *I understand the provisions of this document and execute it voluntarily.*

Important Medical Information

Any medical problems: ☐ **Yes** ☐ **No If yes, list any medical problems your child has which medical personnel need to be aware of in an emergency (examples: asthma, diabetes, heart problems, pregnancy, seizures):**

List any prescription or non-prescription medication you child takes daily either at home or school. Obtain a permission form from the nurse if medication is needed to be given to your child at school.

Any severe allergies to insect bites: ☐ **Yes** ☐ **No** **Any severe allergies to peanuts:** ☐ **Yes** ☐ **No**

Family Physician:	Phone Number:
Health Insurance Company Name:	Phone Number:
Group Number:	Policy Number:

Parent/Guardian Contact Information

Parent/Guardian Last Name (Print):	Parent/Guardian First Name (Print):	Parent/Guardian Middle Name:
Daytime Phone Number:	Nighttime Phone Number:	Cell Phone Number:
Parent/Guardian Signature:		Date: