BRITTEN SCHOOL
AUGUST 2023- AUGUST 2024
AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Student's Name: _____ Date of Birth: _____

Address: _____
street address apt/unit #

_____
city state zip

Parent/Guardian Phone: _____

Primary Physician: _____

Physician's Address: _____ Phone: _____
street address suite/office number

_____
city state zip

Known Allergies**:** _____

_____

Chronic Illnesses/Medical Problems: _____

_____

I, _____, Parent/Guardian of _____, and having custody of same, do hereby agree to the following authorizations:

1. I authorize a physician to perform the procedures that may be necessary for the emergency diagnosis and treatment of the above-named student while currently in the program at Britten School in the event I am unable to be contacted or am unavailable for immediate written or telephone authorizations.
2. I authorize Britten School to release the above medical information, which is relevant to the emergency examination and treatment.
3. I authorize that a photocopy of this authorization be accepted with the same authority as the original.

I, _____, understand that Britten School cannot assume financial liability for expenses incurred for transportation and during an emergency room visit.

_____ _____
Parent/Guardian Signature **Date**