

BRITTEN SCHOOL
AUGUST 2026- AUGUST 2027
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

Seasonal Allergies: _____ Food Allergies: _____ Epi Pen: _____
Yes or No Symptoms List Reaction Yes or No

Other Allergies: _____ Describe Reaction: _____

Asthma: _____ Inhaler: _____
Yes or No Symptoms Yes or No

Other Medical Conditions: _____

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