Honolulu Waldorf School

Medical Treatment Authorization Form

This form grants temporary authority to designated adult(s) to provide and arrange for medical care for a minor in the event of an emergency, where the minor is not accompanied by either parents or legal guardians, and it may not be feasible or practical to contact them. This completed form should be given to the enrollment coordinator, the school front office and the host parents. A copy will be kept in the student file.

Minor's Full Legal Name:_____

Address _____

City: _____ Province/State: _____ Country: _____Postal Code:_____

Date of Birth: (month/day/year) _____Gender: ❑ Male ❑ Female

Medical Insurer/Health Plan: _____Policy #: _____

Allergies to Medications: _____ Allergies (Other): _____

Note any other significant medical information: _____

_____

AUTHORIZATION AND CONSENT FOR HOST PARENT/S

I/We, parents/legal guardians of_____, do hereby state that I have legal custody of the aforementioned Minor. I/We grant authorization and consent for:

Host Parent 1 (Legal Full Name): _____

Host Parent 2 (Legal Full Name): _____

Weare also approving any employee of the Honolulu Waldorf School, in case of emergency, to administer and or take the minor student to seek medical attention._____(parent 1 initials)_____ (parent 2 initials) (hereafter "Designated Adult/s") to administer general first aid treatment for any minor injuries or illnesses experienced by the Minor. If the injury or illness is life threatening or in need of emergency treatment, I authorize the Designated Adult or School Employee to summon any and all professional emergency personnel to attend, transport, and treat the minor and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the state in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care. It is understood that this authorization is given in advance of any such medical treatment, but is given to provide authority and power on the part of the Designated Adult or School Employee in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

This authorization is effective through:

Start Date: (Month/Day/Year) _____ End Date: (Month/Day/Year) _____

Signed this _____ day of _____ , 20 _____
DAY MONTH YEAR

Parent 1/Legal Guardian PRINT FULL Name: _____

Parent 1/Legal Guardian Signature: _____

Parent 2/Legal Guardian PRINT FULL Name: _____

Parent 2/Legal Guardian Signature: _____