3590 W. 18th Ave • Eugene, Oregon 97402 • 541-686-1223 • Fax 541-687-1493

EMERGENCY MEDICAL TREATMENT AUTHORIZATION

The undersigned parent or guardian of _____
(Student's full legal name)

hereby authorizes staff of Wellsprings Friends School to transport and seek emergency medical or surgical treatment to this minor student.

Student's Date of Birth _____

Parent Name _____ (Cell) Phone _____

Home Address _____

Employer _____ Work Phone _____

Other Emergency Contact _____ Phone _____

Family Physician _____ Phone _____

Health Insurance Co. _____ Group ID _____

Medical conditions, allergies, etc. _____

Current Medications _____

This authorization shall be effective for as long as my student is enrolled at WFS.

Parent Signature _____ Date _____

AN ATTEMPT WILL BE MADE TO NOTIFY PARENTS IMMEDIATELY IN THE EVENT OF AN EMERGENCY, BEFORE TREATMENT IS PROVIDED.