DUNN SCHOOL PO Box 98, Los Olivos, CA 93441 Phone: (805) 686-0626 Nurse's Fax: (805) 688-3421

AUTHORIZATION FOR TREATMENT FORM

This form constitutes a permission statement which must be signed by a parent or guardian. The completed form must be returned to the Dunn School Health Office. This health record is to be completed by the parent or guardian. **Please complete the entire form!** (PLEASE PRINT)

Student Name:_____ Entering Grade:_____
Last First Middle

Date of Birth:_____ Male/Female (Circle one) Student resides with: Both Parents/ Mother / Father / Other (Circle one)

Parent 1:
Name:_____
Address: _____
City, State, Zip: _____
Home Phone: _____
Work Phone: _____
Fax: _____
E-mail: _____
Cell: _____

Parent 2:
Name:_____
Address:_____
City, State, Zip: _____
Home Phone: _____
Work Phone: _____
Fax: _____
E-mail:_____
Cell: _____

In Case Parent cannot be reached:
Name:_____
Home Phone: _____
Work Phone: _____
Fax: _____
E-mail: _____
Cell: _____

Person Responsible for medical expenses:
Name:_____
Home Phone: _____
Work Phone: _____
Fax: _____
E-mail:_____
Cell: _____

Significant Medical Problems, Illnesses, or Past Surgeries: _____
_____
Allergies (Please list medication, food, and seasonal allergies): _____
_____
Medication (Please list medications that the student is taking): _____
_____
Contraindications on Medication:_____
Must take medication_____ Can refuse medication_____
Date of last tetanus:_____ Last TB test or chest x-ray_____

Authorization to consent to treatment of a minor

I, We, the parent(s)/guardian of _____, a minor, do hereby authorize any Dunn School personnel in Los Olivos, CA as agents of the undersigned to consent to any medical procedure, x-ray examination, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by and is to be rendered under the general or special supervision of any physician or surgeon licensed under the provisions of the California Medical Practice Act, whether such diagnosis or treatment is rendered at the physician's office or at a hospital. The authorization also applies to dental care under a duly licensed dentist and psychological care.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) or any organization involved including without limitation the Dunn School. Dunn School will not assume any financial responsibility for exercising this action.

This authorization is given and shall remain effective until revoked in writing and delivered to said agent(s).

_____ Date:_____
Signature of parent(s) or legal guardian of the student named above