Exhibit A—Authorization to Consent to Medical Treatment of a Student

Note to parent or guardian: In accordance with the law, a District may consent to medical treatment, which includes dental treatment, if necessary, for a student if the District has received written authorization from a person having the right to consent, that person cannot be contacted, and that person has not given the District actual notice to the contrary. This authorization form will be used by the District when a student's parent or authorized designee is unable to be contacted. A student may provide consent if authorized by law or court order.

Regardless of parental authorization for the District to consent to medical treatment, District employees will contact emergency medical services to provide emergency care when required by law or when deemed necessary, such as to avoid a life-threatening situation.

Part 1

Please read Part 1 in its entirety and choose the option that you wish the school to follow for your child regarding medical care and treatment, including dental treatment, at school or school activities.

(Please print.)

Student's name: ______________________________

Date of birth: ______________________________

Grade: ______________________________

Name of parent or guardian giving consent below: ______________________________

Address: ______________________________

Work phone number: ______________________________

Home phone number: ______________________________

Mobile phone number: ______________________________

Alternate person(s) to contact if parent or guardian cannot be reached who is/are authorized to consent to the student's medical treatment:

Name: ______________________________

Phone number: ______________________________

Relationship to student: ______________________________

Student's physician or other preferred health-care provider

Name: ______________________________

Phone number: ______________________________

Student's dentist

Name: ______________________________

Phone number: ______________________________

Medications or drugs to which the student has an allergic or adverse reaction

____

Option One:

☐ If I, or the alternate contact person I designated above, cannot be reached, I authorize school officials to secure any and all necessary medical care and treatment, which includes dental treatment, if necessary, for the above-named student for illness suffered, injury sustained, or other situation requiring medical treatment while at school or participating in school-related activities. If medical treatment can only be secured off school property, I prefer that my child be taken for care and treatment at the following medical facility: ______________________ *(name of preferred medical facility)*. I understand that the District may not be able to utilize the designated medical facility and may use another licensed hospital, clinic, or medical facility, if necessary, to ensure proper care for my child.

I further understand that the District will contact emergency medical services for emergency care either as required by law or when deemed necessary, regardless of the consent authorized herein for medical treatment. I understand the District assumes no responsibility for care provided by emergency services personnel.

I understand that cost of services provided by ambulance, private physician, clinic, hospital, or dentist remains the responsibility of the parent or guardian and will not be assumed by the District or any of its officers or employees.

(Check one)

☐ **I do** have medical insurance coverage on my child with:

____

☐ **I do not** have medical insurance coverage on my child.

Parent's or guardian's signature: ______________________________

Date: ______________________________

Option Two:

☐ School officials are not authorized to secure any and all medical care or treatment for the above-named student while at school or participating in school-related activities.

I further understand that the District will contact emergency medical services for emergency care either as required by law or when deemed necessary, regardless of the consent authorized herein for medical treatment. I understand the District assumes no responsibility for care provided by emergency services personnel.

I understand that cost of services provided by ambulance, private physician, clinic, hospital, or dentist remains the responsibility of the parent or guardian and will not be assumed by the District or any of its officers or employees.

Parent's or guardian's signature: ______________________________

Date: ______________________________

Part 2

[Include this section only if the District's FFAC(LOCAL) permits administration of nonprescription medication for secondary students to prevent or treat illness or injury in the District's athletic program.]

The District's athletic trainer or medical advisor:

(Choose only one.)

☐ **May administer** nonprescription medication to my child to prevent or treat illness or injury related to participation in the District's athletic program.

☐ **May not administer** nonprescription medication to my child to prevent or treat illness or injury related to participation in the District's athletic program.

Parent's or guardian's signature: ______________________________

Date: ______________________________

Copies of this authorization may be presented to the admissions office of a hospital or clinic or to a physician or dentist. Other distribution will occur only within the limitations of the Family Educational Rights and Privacy Act.