

**Methow Valley School District  
Authorization for Emergency Medical / Dental Treatment**

Student \_\_\_\_\_ Date of birth: \_\_\_\_\_ Date: \_\_\_\_\_

**I authorize the principal or his/her designee to transport and seek emergency medical or dental treatment** when the need for such treatment is immediate and when efforts to contact me are unsuccessful. This authorization shall remain effective for the full school year unless revoked in writing and delivered to the Methow Valley School District.

**I do NOT authorize or consent to emergency medical or dental treatment for my child.** Please specify procedure to follow if child has problems, until parents can be contacted:

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I understand that the Methow Valley School District, its employees and its Board of Directors assume no liability of any nature in relationship to the transportation or treatment of the said minor. I further understand that all costs of EMS transportation, hospitalization, examination, x-ray or treatment provided in relation to this authorization shall be my responsibility.

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**Signature of parent/guardian**

**Date**