AUTHORIZATION FOR MEDICAL TREATMENT OF MINOR

(I), (We), the parents of:

Minor _____
Last Name First

Do hereby authorize representatives of **Valley School** and give my permission for them to sign any necessary papers to give consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by any licensed physician or the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

It is understood that this authorization is given in advance of any specific consent to any and all diagnosis, treatment or hospital care, which the aforementioned physician in the exercise of his best judgment may deem advisable.

This authorization shall remain in effect for the period that my child is enrolled at Valley School.

Today's date: _____ City and State: _____

_____
Signature of Parent or Guardian Phone Number

Allergies, if any: _____

Any daily medication or other special health data: _____

_____

_____
Name and address of insurance company

_____
Policy Number Certificate Number