Office Use Only: I T P 3B H TB C K SA

AUTHORIZATION FOR ANOTHER TO CONSENT TO TREATMENT OF CHILD

As a parent or legal guardian of: ____ D.O.B. ____________

I hereby authorize: **Valley View Dayschool**, 11501 SE Sunnyside Road, Suite 100, Clackamas, OR 97015, (503) 698-6003, to consent to any medical or surgical treatment of the above child which such person deems advisable if a parent or legal guardian cannot reasonably be located when the child is brought for treatment. In an emergency, I authorize Valley View Dayschool to transport my child by ambulance or private car to the nearest available hospital or medical facility.

This authorization is effective as of **September 1, 2016** and is good thru **August 31, 2017**. (By law may not exceed 12 months)

Parent/Guardian Signature: ____ Date: _________________

Please Print Clearly

MOTHER or guardian name: ____

Home address: ____ City ________________ Zip ________

Name of Employer: ____

FATHER or guardian name: ____

Home address: ____ City ________________ Zip ________

Name of Employer: ____

Contact Phone Numbers – VVDS will call in the order given below. Please indicate who the number belongs to.

#1 (_______) _______-__________	H	W	C	Mom	Dad
#2 (_______) _______-__________	H	W	C	Mom	Dad
#3 (_______) _______-__________	H	W	C	Mom	Dad
#4 (_______) _______-__________	H	W	C	Mom	Dad
#5 (_______) _______-__________	H	W	C	Mom	Dad
#6 (_______) _______-__________	H	W	C	Mom	Dad

EMERGENCY CONTACT (other than parent)

Name: ______________________________________ Relationship to child: ____________________

Cell # ____________________ Home # ____________________ Work # ____________________

Family Physician: ____ Phone # ____________________

Insurance Info: ______________________________ Hospital Preference: _____________________

Permission of Application

Yes ❑ No ❑ VVDS may apply Neosporin to minor cuts and scratches

Yes ❑ No ❑ VVDS may apply Sunscreen (UVA/UVB, SPF 30, waterproof, hypoallergenic, PABA-free, oil free)
Please apply sunscreen prior to arrival. Sunscreen will not be applied until after nap/rest time.

❑ I would prefer to provide my own sunscreen for my child

Medical Information – PLEASE UPDATE THIS FORM IF THERE ARE ANY CHANGES – Additional info on back? Y N

Date of last DTaP Immunization: _____________ (we need you to record the actual date)

Chronic Illnesses: ____

Food Allergies: ____

Medication Allergies: ____

Current Medications: ____

Has your child had Chicken Pox? Y N When? ______________________