Official school medical care permission

Subject: Annual Medical Treatment Authorization for [Student Name]

Dear [School Name] Administration and Staff,

I, [Parent/Guardian Name], hereby authorize school personnel and designated medical professionals to provide or arrange necessary medical care for my child, [Student Full Name], Grade [Grade Level], during the [School Year] academic year.

This authorization covers:

- First aid treatment for minor injuries
- Administration of prescription medications per doctor's orders
- Emergency medical treatment including ambulance transport
- Communication with emergency medical services
- Contact with our family physician when necessary

STUDENT MEDICAL PROFILE:

- Chronic conditions: [list conditions like asthma, diabetes, etc.]
- Daily medications: [list with administration times]
- Emergency medications: [EpiPen, inhaler, etc.]
- Allergies/restrictions: [food, environmental, drug allergies]
- Physical limitations: [any restrictions on activities]

EMERGENCY PROTOCOL:

1. Provide immediate necessary care
2. Call 911 if serious emergency
3. Contact parent at [primary phone]
4. Contact [emergency contact] at [phone] if parent unavailable
5. Transport to [preferred hospital] if needed

Our family physician is Dr. [Name] at [phone]. Insurance carrier: [name and policy number].

This authorization remains valid for the entire school year unless revoked in writing.

Respectfully submitted,

[Parent Signature]

[Printed Name]

[Date]

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