Salt River Pima Maricopa Indian Community
S.T.E.P. Up Tutoring Program
2007-2008
Consent for Emergency Care

SITE: Salt River High School-After School DATE: _____

STUDENT: _____ DOB: _____

ADDRESS: _____ HM PHONE: _____

_____

FATHER: _____ WK PHONE: _____

MOTHER: _____ WK PHONE: _____

OTHER: _____ PHONE: _____

RELATIONSHIP: _____

DOCTOR: _____ PHONE: _____

HOSPITAL PREFERENCE: _____

PHONE: _____

INSURANCE CO: _____

POLICY #: _____

HEALTH PROBLEMS: Circle if Appropriate

ASTHMA DIABETES EPILEPSY BEE STING ALLERGIES

HEART PROBLEMS SEIZURES FOOD ALLERGIES

OTHER/SPECIFY: _____

MEDICATION: _____

CONSENT FOR STUDENT EMERGENCY CARE

BE IT KNOWN, that in the event I cannot be reached, I, the undersigned parent or guardian of the student above named, hereby give and grant unto any medical doctor or hospital my consent and authorization to render such aide, treatment or care to said student as, in the judgment of said doctor or hospital may be required, on an emergency basis, in the event sa student should be injured or stricken ill while participating in the S.T.E.P. Up Tutoring After School Program at Salt River High School.

IT IS HEREBY understood that the consent and authorization hereby given and granted are continuing, and are intended by me to extend throughout the current school year.

IT IS FURTHER understood that any expenses incurred will be paid for by insurance or the parent of the student. Payment of the expense is not a school or the S.T.E.P. Up Tutoring Program responsibility.

_____ Yes, I give my consent. _____ No, I do not give my consent.

SIGNATURE: _____ **DATE:** _____

Parent or Guardian

SIGNATURE: _____ **DATE:** _____

Sarah Heady, After School Supervisor