

THE URBAN SCHOOL

MEDICAL CONSENT/AUTHORIZATION FOR TREATMENT OF A MINOR

Student Name: _____ Birth Date: _____ Grade: _____

Address: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Emergency Contact Name: _____ Contact Phone #: _____

Physician Name: _____ Phone #: _____

Health Plan/Insurance: _____ Group/Policy #: _____

In case of a local emergency, please treat my son/daughter at the following facility:

List all medications presently being taken:

List any allergies: _____

1. I am the parent or legal guardian of the above-named student (the "Student"). I understand that participation in the following trip organized by The Urban School, a California nonprofit public benefit corporation (the "School"): to France scheduled for March 1 through March 16, 2019 (the "Trip") involves certain risks and hazards and that the Student may require emergency medical treatment as a result thereof. I hereby authorize the School, acting as my agent, to consent to (i) any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician or surgeon licensed in the state, territory, province, locality or country where the physician or surgeon is located or (ii) any x-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care by a dentist licensed in the state, territory, province, locality or country where the dentist is located, or (iii) the foregoing in (i) and (ii) administered or performed by the staff of any acute general hospital holding a current license to operate a hospital in the state, territory, province, locality or country where it is located.

I understand that this authorization is being given in advance of any specific diagnosis, treatment or hospital care being required, but is given to provide authority and power to the School to give specific consent to any and all such diagnosis, treatment or hospital care which an aforementioned physician, dentist, or staff in the exercise of his or her best judgment may deem advisable.

2. Pursuant to Section 1283 of the California Health and Safety Code, I hereby authorize any health facility that provided treatment to the Student to surrender the physical custody of the Student to the School following treatment given pursuant to the authorizations in this form.

3. I understand that it is important that the School has my permission to share the medical care and emergency contact information of the Student with the involved school officials, such as School faculty members, trip chaperones, school nurse, and/or health office. My signature below authorizes these individuals to access the Student's medical and emergency records on file in the school health office and to share this information with involved school officialsemergency medical personnel, hospital or other health care professional who evaluates, diagnoses or treats an injury, illness or other condition incurred by the Student while participating in the Trip, as deemed necessary.

4. The authorizations given in this form shall remain effective until the conclusion of the Trip.

5. I have consulted a physician of my own choice and have been advised by said physician that the Student is in good health, and does not suffer from any physical or mental ailment or disability which would make his or her participation in the Trip hazardous, unwise, unwarranted or a potential source of danger to the Student or others who may participate in the Trip.

6. I understand and acknowledge that I am responsible for, and agree to fully pay, all costs of medical and/or dental care incurred by the Student and rendered pursuant to the authorizations given in this form, including, but not limited to, the cost of medical evacuation, paramedic transportation, hospitalization, and any examination, x-ray, or other treatment provided pursuant to the authorizations given in this form. I further understand and agree that my insurance is primary and non-contributory to any insurance that the School may carry. I agree to indemnify, defend and hold the School and its trustees, officers, employees and representatives harmless from and against (i) any claim by a medical care provider or insurance coverage provider for the cost of medical or dental care provided to the Student and (ii) any medical bills paid by the School on the Student's and/or my behalf.

I have read and agree to the foregoing Medical Consent/Authorization for Treatment of Minor.

Parent's/Guardian's signature: _____

Print name: _____

Date: _____

Parent's/Guardian's signature (required if more than one parent/guardian):

Print name: _____

Date: _____