Lincoln-Way Area Special Education
Joint Agreement District 843

601 Willow Street
Frankfort, IL 60423
Phone: 815.806.4600
Fax: 815.806.4601

PARENTAL CONSENT FORM FOR EMERGENCY MEDICAL TREATMENT

I, _____, am the parent or legal guardian of _____, on this _____ day of _____, 20____. I hereby authorize and consent to Lincoln-Way Area Special Education Joint Agreement District 843, its employees and agents, and Dr. _____, my child's physician, or any physician in their group practice, on my behalf and in my stead, to administer emergency medical assistance to my child. This permission and consent extends to the right of Lincoln-Way Area Special Education Joint Agreement District 843, its employees and agents, to arrange for immediate medical treatment by a licensed physician and/or other medical personnel, and for such physician or other medical personnel to apply such emergency techniques which in their judgment they deem appropriate to treat any injury sustained by my child. I further authorize Lincoln-Way Area Special Education Joint Agreement District 843, by and through its employees and agents, to administer such emergency medical treatment as is necessary for the health and welfare of my child.

I do hereby agree to hold harmless and indemnify Lincoln-Way Area Special Education Joint Agreement District 843, its Board, officers, administrators, employees and agents, either jointly or severally from and against any and all claims, demands, damages or causes of action, or injuries, including reasonable attorneys fees and costs in the defense thereof, resulting from or arising out of the provision of emergency medical treatment by school personnel or by a physician and/or other medical personnel.

_____
Parent/Guardian Signature

_____
Parent/Guardian Printed Name