PERMISSION TO TREAT

_____

student name(s)

I) IN CASE OF A MEDICAL EMERGENCY: We understand that every effort will be made to contact parents first. In the event that I/we cannot be reached, I/we hereby give permission to the physician selected by the school, or its authorized representative, to hospitalize and secure proper treatment, including surgery, for my/our child as named above.

II) I/we authorize Buxton School to administer COVID tests to my/our student at their discretion. These tests may be administered on campus by the school nurse or at a local medical center.

_____ _____

(signature of parent/guardian) (date)

_____ _____

(signature of parent/guardian) (date)