

**Dominion School for Autism
Permission for School Personnel to Consent to Medical Treatment
Summer 2008 and School Year 2008-2009**

In the event of a situation in which immediate medical decisions need to be made

to protect the well-being of my child, I _____,
Parent/Guardian's Name

the parent/ guardian of _____,
Student's Name

authorize the Director of the Dominion School or her designee to make medical

decisions on behalf of my child, should I, or other emergency contacts, not be

reached with all reasonable effort. The Director of Dominion School or her

designee agrees that she will act prudently and will rely on the advise of medical

professionals who are providing care for my child.

Provided is a copy of my child's medical insurance card.

Parent/Guardian's Signature

Date