

**CNMI PUBLIC SCHOOL SYSTEM
EMERGENCY MEDICAL TREATMENT AUTHORIZATION FORM**

This form grants temporary authority to a designated school official to provide and arrange for medical care for a minor who is a CNMI PSS student in the event of an emergency, where the student is not accompanied by either parents or legal guardians, and it may not be feasible or practical to contact them.

Medical History information is found in your child's record in the Student Information System. During the online registration and re-enrollment process, you are given access to this tab. Please ensure that the information found in the Medical History Tab in your child's record have been updated for the new school year.

If you have not been given access to your child's record, please notify your school's administrator and/or registrar right away.

Notice of medical records disclosure:

Your child's medical information that have been provided to the school are student records which are subject to the requirements of FERPA, 20 U.S.C.A. 1232g. Accordingly, that information can be disclosed without the written consent of the parent/guardian as allowed by FERPA, including if used by a teacher or other school official, who has a legitimate educational interest, or if disclosure is to an appropriate party and is necessary to protect the health or safety of the student or other individuals.

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I do hereby state that I have legal custody of the aforementioned student. I grant my authorization and consent for the CNMI Public School System school official (hereafter "Designated Adult") to administer general first aid treatment for any minor injuries or illnesses experienced by the student. If the injury or illness is life threatening or in need of emergency treatment, I authorize the Designated Adult to summon any and all professional emergency personnel to attend, transport, and treat the minor and to issue consent for any X-ray, anesthetic, blood transfusion, medication, or other medical diagnosis, treatment, or hospital care deemed advisable by, and to be rendered under the general supervision of, any licensed physician, surgeon, dentist, hospital, or other medical professional or institution duly licensed to practice in the CNMI in which such treatment is to occur. I agree to assume financial responsibility for all expenses of such care. It is understood that this authorization is given in advance of any such medical treatment, and is given to provide authority and power on the part of the Designated Adult in the exercise of his or her best judgment upon the advice of any such medical or emergency personnel.

This authorization is effective through: SY 2020-2021.

Parent / Legal Guardian eSignature - On the online registration and/or re-enrollment form, enter the following in the designated field for this form: Your Initials, birthdate, and Photo ID number that was uploaded in the Contacts tab as Proof of Identity.

Example:

Initials – ABCD, Birthdate (mm/dd/yyyy) – January 31, 1950, Driver's License Number (Photo ID) – 123456

How your "esignature" will be entered: ABCD01311950123456