Katy Independent School District

Parent Authorization to Consent to Emergency Treatment of Student

Name of Student: (Last) (First) (Middle)	Date of Birth (mm/dd/yyyy)	Grade Level

As the parent(s)/guardian(s) of the above-named student, a minor, I/we do hereby authorize a Katy Independent School District staff member(s), to act as my/our agent(s), to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and/or hospital care which is deemed advisable by, and is to be rendered under, the general or special supervision of any licensed physician/surgeon, whether such diagnosis or treatment is rendered at the office of said physician/surgeon or at a hospital. Parents/guardians will be notified by the district, by the contact information below, of any treatment rendered to the student.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital care which aforementioned physician/surgeon, in the exercise of his/her best judgment, may deem advisable, prior to any treatment being rendered.

I/We hereby authorize any hospital which has provided treatment to the above-named minor to surrender physical custody of such minor to the agent(s) upon completion of treatment.

It is understood that I/we must assume legal responsibility for any expenses incurred for medical treatment which may not be covered by my/our personal insurance, Medicaid, or Medicare.

Name of Father/Guardian: (Last) (First) (Middle)		
Father's Home Phone	Father's Work Phone	Father's Cell Phone
Name of Mother/Guardian: (Last) (First) (Middle)		
Mother's Home Phone	Mother's Work Phone	Mother's Cell Phone

I/We have read and understand the extent of this authorization and that it shall remain effective until the end of the current school year, from August 1, 20___ through July 31, 20___.

Signature of Parent/Guardian:	Date

Insurance Information

Name of Insured Policyholder: Last First Middle			
Billing Address of Policyholder: Street	City	State	Zip
Insurance Company			
Group No.:	Certificate or Policy No.:		

Type of Insurance Plan

❑ HMO ❑ PPO ❑ Medicaid ❑ Medicare ❑ Other: _____

Please note my child has the following allergies/medical conditions and/or is currently taking the following medications: