

Parent Authorization to Consent to 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.

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.

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.

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, 20__-20__.

Name of Parent/Guardian: (Last)	(First)	(Middle)	Date
Signature of Parent/Guardian:			Date

STATE OF TEXAS
 COUNTY OF _____

BEFORE ME, the undersigned authority, on this day personally appeared _____ known to me to be the person(s) whose name(s) is/are subscribed to the foregoing instrument and acknowledged to me that he/she/they executed the same for the purpose and considerations therein expressed.

GIVEN under my hand and seal of office on this the _____ day of _____, 20_____.

(Affix Notary Seal)

 Notary Public, State of Texas

 Printed Name of Notary Public

Contact and Insurance Information

Name of Father: Last	First	Middle
Father's Home Phone	Father's Work Phone	Father's Cell Phone
Name of Mother: Last	First	Middle
Mother's Home Phone	Mother's Work Phone	Mother's Cell Phone

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 <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Other: _____		