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:

Revised: 08-05-2014
Health Services Department

Katy Independent School District

Parent/Guardian Authorization for Regular Extracurricular Travel

Student's Last Name	First Name	Middle Name	Grade Level

Extracurricular Activity	School Year

As the parent/guardian of the above-named student (or adult student), I grant permission for my child (or me) to travel and participate in all regularly/routinely scheduled activities of the designated extracurricular group for the current school year. I understand that all students are required to ride to and from all school-sponsored activities in District-provided transportation according to Board Policy FMG. An exception may be granted for a student to be released to the custody of his/her parent at the completion of the activity if a written request is received and approved prior to the trip. It is understood that a separate permission slip will need to be completed for any additional activities requiring travel in order for my child to participate.

It is understood that neither the Katy Independent School District, nor any of its trustees, officers, employees, or organization sponsors are liable for any accident or injuries that may occur to the above-named student as a result of any aspect of his/her participation on these trips.

I acknowledge that in case of an emergency, illness, or accident for which a parent cannot be reached, an attempt will be made to reach one of the emergency contact people listed below. However, if no one can be reached, I authorize the school officials to take whatever action is deemed necessary in their judgment, for the health of my child. I will be responsible for any cost in the event my child must be transported by ambulance and receive medical care.

Insurance Information

Insurance Company	
Policy Number	Group Number
Insured's Name	

Medical Information

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

PLEASE PRINT

Emergency Contact Information

Emergency Contact		Relationship
Home Phone	Work Phone	Cell Phone
Emergency Contact		Relationship
Home Phone	Work Phone	Cell Phone
Emergency Contact		Relationship
Home Phone	Work Phone	Cell Phone

Authorization

Parent's/Guardian's (or Adult Student's) Printed Name	Parent's /Guardian's (or Adult Student's) Signature	Date
Father's/Guardian's Home Phone	Father's/Guardian's Work Phone	Father's/Guardian's Cell Phone
Mother's/Guardian's Home Phone	Mother's/Guardian's Work Phone	Mother's/Guardian's Cell Phone

Revised: 08-06-2008
Special Services Department