	Center Independent School District Health Services *Authorization to Secure Emergency Medical Treatment of a Student*	School Year **2021-2022**

Student's Name (print): _____

Date of Birth: _____ Grade: _____

Name of Parent or Guardian: _____

Address: _____

Work Phone Number: _____

Home Phone Number: _____

Mobile Phone Number: _____

LOCAL PERSON TO CONTACT IF PARENT OR GUARDIAN CANNOT BE REACHED

Name: _____

Phone Number: _____

Relationship to student: _____

STUDENT'S PHYSICIAN OR OTHER PREFERRED HEALTHCARE PROVIDER

Name: _____ Phone Number: _____

STUDENT'S DENTIST

Name: _____ Phone Number: _____

Medications or drugs to which the student has had an allergic or adverse reaction: _____

I hereby authorize the Superintendent of Center Independent School District or a designated representative to secure any and all emergency medical care and treatment for _____ (student's name) for acute illness suffered, injury sustained, or other situation requiring emergency medical treatment while at school or participating in school-related activities. I prefer that emergency treatment be secured at _____ (name of preferred medical facility).

The District may use another licensed hospital, clinic, or medical facility, if necessary, with the following exceptions: _____

_____

I understand that the cost of services provided by ambulance, private physician, clinic, hospital, or dentist remains the responsibility of the parent or guardian and will not be assumed by the District or any of its officers or employees.

Check One:

☐ I do have medical insurance coverage on my child with _____

☐ I do not have medical insurance coverage on my child.

_____ _____

Parent's or Guardian's Signature Date

**Copies of this authorization may be presented to an Admissions Office of a hospital, clinic, physician or dentist. Other distribution will occur only within the limitations of the Family Educational Rights and Privacy Act.