2015-2016 **Authorization to Consent to Treatment of a Minor** **S-01**

Student's Name_____ Birthdate:_____/_____/_____ Student ID#:_____
Print (Last),(First)(Middle (Mo) (Day) (Yr)

Sex: (circle one) M F Grade Level:_____ Sport_____

Home address:_____ Zip:_____

Home phone w/area code:_____

Father's name:_____ Business/Cell phone:_____

Mother's name_____ Business/Cell phone:_____

List another person to be notified in case of emergency if parents are not available:

1._____ Relationship:_____

Home phone:_____ Business/Cell phone:_____

Special Medical Conditions to be noted (i.e. Allergies, Medications, Disorders)_____

_____

(I)(We), the undersigned, parent(s) do hereby authorize any official of Spring Branch Independent School District to act as designee for the above named minor to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is prescribed by, and is to be rendered under the special supervision of, any licensed physician/or surgeon, whether such diagnosis or treatment is rendered at the office of said physician/or surgeon or at a hospital or elsewhere.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being rendered and is given to provide authority and power on the part of our aforesaid designee to give specific consent to any and all such diagnosis, treatment or hospital care which the aforementioned physician/surgeon may, for reasons he/she deems appropriate, prescribe.

(I)(We), hereby authorize any hospital which has provided treatment to the above named minor to surrender physical custody of such minor to (my)(our) named designee(s) upon completion of treatment. This authorization is given for designee(s) for those times that (I)(We) cannot be reached by telephone at home or work at the numbers listed below.

This authorization is not to be construed as releasing any physician or surgeon from any requirement that he or she adhere to the lawful standard of care in attending to the named minor and is not to be construed as creating any financial responsibility on the part of the Spring Branch Independent School District or the named officials thereof for any health care provided the named minor. PARENTS ARE RESPONSIBLE FOR PAYMENT.

This authorization shall become effective as of_____ 2015 and remain effective until_____ 2016.

Signature of Parent or Legal Guardian: _____

Insurance Information

Insurance information is required. Please provide a photocopy of your insurance I.D. Card.

Insurance Company Name:_____

Policy Number:_____ **Group Number:**_____

Name on Policy:_____

For Office Use Only: SBISD Ins.? Yes No