

Katy Independent School District  
**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)<br>(Middle) | (First) | 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: _____   |                              |                                   |                                   |