AUTHORIZATION TO SECURE EMERGENCY MEDICAL TREATMENT OF A STUDENT

Student's name: _____

Date of birth: _____ Grade: _____

Name or parent or guardian: _____

Address: _____

Work phone: _____ Home phone: _____

Mobile phone: _____

Local person to contact if parent or guardian cannot be reached:

Name: _____

Phone: _____

Relationship to the student: _____

Medical Conditions: _____

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

IF STUDENT TAKES MEDICATIONS, PLEASE COMPLETE MEDICATION PERMISSION FORM & NOTIFY MISD PERSONNEL***

Does this student have an Individual Health Plan or an Emergency Action Plan on file with school nurse? Y _____N_____ (INITIAL)***

Does this student have a form on file with the nurse allowing them to self carry an inhaler or EPI-PEN? Y _____N_____ (INITIAL)***

***** IF YES to ANY, NOTIFY SCHOOL NURSE ONE WEEK PRIOR TO SCHOOL TRIP**

School Nurse: _____

Signature: Date:

EXHIBIT B (PAGE 2)

Student's physician or other preferred health-care provider:

Name: _____

Phone: _____

Student's dentist:

Name: _____

Phone: _____

Part 1:

I hereby authorize the Superintendent of Midland 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 understand that 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.

☐ I do have medical insurance coverage for my child with:

_____ (Attach photocopy of insurance card).

☐ I DO NOT have medical insurance coverage for my child.

_____ _____
Signature of parent or guardian Date

I understand that the District will attempt to contact me as soon as possible if such action is necessary.

_____ _____
Signature of parent or guardian Date

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