

**PRINCETON INDEPENDENT SCHOOL DISTRICT
AUTHORIZATION TO SECURE EMERGENCY MEDICAL TREATMENT FOR A MINOR STUDENT**

Name of minor _____ Grade _____

Date of Birth _____
Month Day Year

Name of parent, guardian, or conservator _____

Office phone _____ Home phone _____ Mobile phone _____

Address _____

Name of other parent (or both if different from above)

Father _____ Telephone _____

Mother _____ Telephone _____

Name of friend or relative who will probably know where to locate the parent in the event of temporary absence

Name _____ Telephone _____

This is to certify that I authorize the Superintendent of Princeton Independent School District, Princeton, Texas, or a designated representative to secure any and all emergency medical care and treatment for _____ for acute illness suffered or injury while at school or participating in school-related activities. This emergency treatment may be secured at a licensed hospital, clinic, or medical facility, or by a licensed physician or dentist with the following exceptions:

Check one:

I { } do not have medical insurance { } do have medical insurance with _____
Insurance Company and I shall assume financial responsibility for any medical treatment of my child.

I understand that the cost of services provided by ambulance, private physician, clinic, hospital, or dentist remain the responsibility of the parent or guardian and shall not be assumed by the superintendent, the designee, or the Princeton Independent School District.

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

Drugs to which the student has had an allergic or adverse reaction are: _____

Father Signature: _____ Date _____

Mother Signature: _____ Date _____

Guardian Signature: _____ Date _____

PLEASE LIST ANY PERTINENT HEALTH CONDITIONS BELOW: