HALLSVILLE HIGH SCHOOL
P O Box 810, Hallsville TX 75650
Phone - 903-668-5990 Fax - 903-668-5990

Authorization to secure <u>emergency</u> medical treatment of a minor student

1. Name of Minor _____ Grade_____
   Date of Birth _____

2. Name of parent/guardian or conservator
   Work Telephone: _____ Home Phone _____
   Cell Phone _____
   Address _____

3. Name of Other Parent (or both if different from #2)
   Father _____ Telephone _____
   Mother _____ Telephone _____

4. Friend or relative who will probably know where to locate the parent in event of temporary absence.
   Name: _____ Telephone _____

This is to certify that I authorize the designated adult sponsor to secure any and all emergency medical care and treatment for _____ for acute illness suffered or injury sustained 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:

_____

_____

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

(Other pertinent health conditions shall be listed on reverse side of this sheet)

I (**) <u>do not have</u>** medical insurance I ( ) **<u>do</u>** have medical insurance with

_____ Insurance Company and I shall assume financial responsibility for any medical treatment of my child. I understand that cost of services proved by ambulance, private physician, clinic, hospital, or dentist remain the responsibility of the parent/guardian and shall not be assumed by any employee of Hallsville Independent School District.

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

Date _____ Signed _____(Father)

Date _____ Signed _____(Mother)

Date _____ Signed _____(Guardian)