

Katy Independent School District

Parent/Guardian Authorization for Regular Extracurricular Travel AND Consent to Emergency Treatment of Student

Student Information				
First Name:	Last Name:	Extracurricular Activity:		
Birthdate:	Gender	Age:	Cell:	
Address:				Zip:
City: Katy	State: Tx	Email:	ID:	School Attending: 7L

As the parent/guardian of the above-named student (or adult student), I grant permission for my child (or me) to travel and participate in all regularly/routinely scheduled activities of the designated extra-curricular group for the current school year. I understand that all students are required to ride to and from all school-sponsored activities in District-provided transportation according to Board Policy FMG. An exception may be granted for a student to be released to the custody of his/her parent at the completion of the activity if a written request is received and approved prior to the trip. It is understood that a separate permission slip will need to be completed for any additional activities requiring travel in order for my child to participate.

It is understood that neither the Katy Independent School District, nor any of its trustees, officers, employees, or organization sponsors are liable for any accident or injuries that may occur to the above-named student as a result of any aspect of his/her participation on these trips.

I acknowledge that in case of an emergency, illness, or accident for which a parent cannot be reached, an attempt will be made to reach one of the emergency contact people listed below. However, if no one can be reached, I authorize the school officials to take whatever action is deemed necessary in their judgment, for the health of my child. I will be responsible for any cost in the event my child must be transported by ambulance and receive medical care.

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. Parents/guardians will be notified by the district, by the contact information below, of any treatment rendered to the student.

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 aforesaid physician/surgeon, in the exercise of his/her best judgment, may deem advisable, prior to any treatment being rendered.

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.

Father / Guardian Information			
Name:	Phone:	Cell:	
Address:	City:	State:	Zip:
Employer:	Employer Phone:	Email:	

Mother / Guardian Information			
Name:	Phone:	Cell:	
Address:	City:	State:	Zip:
Employer:	Employer Phone:	Email:	

Emergency Information		
Emergency Contact Name:	Emergency Relationship:	
Emergency Contact Phone:		
Physician Name:	Physician Phone:	Group Number:
Medical Conditions	Medications	Allergies

Insurance Information (optional)	
Policy Holder:	Group Number:
Insurance Company:	Cert or Policy Number:
Plan Type:	

Parent/Guardian Name (Print): _____ Date: _____

Parent/Guardian Signature: _____