# S&S CONSOLIDATED INDEPENDENT SCHOOL DISTRICT

P.O. Box 837 • Sadler, Texas 76264 • Office: (903) 564-6051 • Fax: (903) 564-3492 • www.sscisd.net

## MEDICAL AUTHORIZATION FORM

I/We, being the parent(s) or legal guardians(s) of ______________________________, a minor,

do hereby appoint an agent of S&S CISD from ______________________________School to
Campus

act in my /our behalf in authorizing emergency medical, dental, or surgical care and hospitalization for the above-named minor during a period of my absence. This authorization is given with my/our understanding that attempts will be made to contact me/us prior to the administration of treatment for any nonlife-threatening situation/condition utilizing the contact information that I/we have provided.

| ______________________________ | ______________________________ |
|---|---|
| Signature Parent/Guardian | Date |
| ______________________________ | ______________________________ |
| Address | City/State/Zip Code |
| ______________________________ | ______________________________ |
| Home Phone | Daytime Phone |

### Hospitalization Coverage for the Above-Named Minor:

| ______________________________ | ______________________________ |
|---|---|
| Name of Insurance Company | Identification or Group Number |
| ______________________________ | ______________________________ |
| Family Physician Name | Family Physician Phone Number |

### Insurance Waiver Statement: (complete this section if you do not have insurance)

Where no proof of insurance is established, it is understood that the parents of the student must assume legal responsibilities for expenses incurred for injuries to students that occur during extracurricular activities. I have read and understand the above.

| ______________________________ | ______________________________ |
|---|---|
| Signature Parent/Guardian | Date |
| ______________________________ | ______________________________ |
| Student's Name | Teacher |