

**AUTHORIZATION TO SECURE EMERGENCY MEDICAL TREATMENT
OF A MINOR STUDENT**

1. Name of minor _____ Grade _____

Date of Birth _____ / _____ / _____
Day Month Year

2. Name of the parent, guardian or conservator _____

Work # _____ Home/Cell# _____

Home address _____

3. Name of other parent (or both if different from #2)

Father _____ Phone # _____

Mother _____ Phone # _____

Friend or relative who will know how to contact the parents in the event they cannot be reached.

Name _____ Phone # _____

This is to certify that I authorize the Superintendent of Randolph Field Independent School District, Randolph Air Force Base, Texas, or a designated representative to secure any and all emergency medical care and treatment for **(student name)** _____

_____ For acute illness suffered or injury sustained while at school or participating in school-related activities. Emergency treatment may be secured at a licensed hospital, clinic or medical facility or by a licensed Physician or Dentist with the following exceptions:

I understand that cost of services provided by ambulance, private physician, clinic, hospital, or dentist remain the responsibility of the parent or guardian and will not be assumed by the Superintendent, the designee, or the Board of Trustees of the Randolph Field ISD.

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

Parent Signature

Date

Parent email address: _____