ARLINGTON INDEPENDENT SCHOOL DISTRICT

MEDICAL AUTHORIZATION

TO: Any Physician, Hospital, or Other Health Care Provider:

RE: _____

We, the undersigned, represent and warrant that we are the parents or legal guardians of the above-named student, a minor child, and we do hereby give _____,

of the Arlington Independent School District, the power to consent to any and all medical and/or health care which he/she deems necessary in an emergency while said child is in his/her custody and control from _____ to _____ ,19____.

Signed this _____ day of _____ ,19____.

_____ _____

Print Name of Parent or Guardian — Signature of Parent or Guardian

_____ _____

Print Name of Parent or Guardian — Signature of Parent or Guardian

SUBSCRIBED AND SWORN TO BEFORE ME by _____

and _____ on this ____ day of _____ ,19 ____,

to certify which witness my hand and seal of office.

Notary Public, State of Texas: _____

My commission expires: _____

ADDITIONAL INFORMATION:

Home Phone: _____ Business Phone: _____

Insurance Company: _____ Insurance Co. Phone: _____

Policy Number: _____

Medical Allergies: _____

Pertinent Medical Information (diabetes, asthma, heart disease, etc.): _____

_____

Medications: _____

Family Doctor: _____ Phone: _____

Other Contact in Emergency: _____ Phone: _____

It will be the responsibility of the parent to notify the school of any changes in the above information.

(For Out-of-District travel, form A-075-95 is also required)