

PIKE COUNTY SCHOOL SYSTEM

AUTHORIZATION TO CARRY STUDENT TO HOSPITAL

I hereby authorize _____ to take my child to the hospital emergency room for treatment. I understand that I am legally responsible for any financial obligations incurred in the emergency treatment of my child.

Name of Student Name of Parent

Social Security Number Date

AUTHORIZATION FOR THIRD PARTY CONSENT TO TREATMENT OF MINOR LACKING CAPACITY TO CONSENT

I/We, the undersigned, parent(s)/person having legal custody/legal guardianship of _____, a minor, do hereby authorize _____, as agent(s) for the undersigned to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon duly licensed, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

These authorizations shall remain effective until _____, 20____ unless sooner revoked in writing delivered to said agent(s).

Date Parent/Legal Guardian

Student Name Student Social Security No.

Student's Birthdate Parent(s)/Guardian Name

Permanent Address (Street, PO Box, City, Zip)

Area Code+Home Phone Area Code+Work Phone/Cell Phone-Parent

Emergency Contact Area Code+Emergency Phone

Insurance Carrier Policy Number