

**Treatment ECTOR COUNTY ISD
AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT**

Student Information		
Student Name:	DOB:	Student ID:
Parent/Guardian Name:	Relationship:	Phone Number:
Emergency Contact Information		
Primary Emergency Contact Name:	Relationship:	Phone Number:
Secondary Emergency Contact Name:	Relationship:	Phone Number:
Medical Information		
Does your student have any medical conditions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
**If yes, please explain:		
Does your student have any allergies to food, medication, insects, etc?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
**If yes, please list:		
Does your student take any scheduled or emergent medications? **If yes, complete the Authorization for Medication Administration Form	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Does your student have an Individualized Health Care Plan or Emergency Action Plan in the school's Health Office? **If yes, please inform school nurse	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Primary Healthcare Provider Name:	Phone Number:	
Insurance Information		
<input type="checkbox"/> My student does NOT have any medical insurance		
<input type="checkbox"/> My student does have medical insurance and the information is listed below		
Insurance Company Name:	Phone Number:	
Plan/Policy Number	Group Number	

I hereby authorize the Superintendent of Ector County Independent School District, or an authorized designated representative, to obtain and consent to any emergency medical evaluation, treatment, or care deemed necessary for _____ (student's full name) in the event of an acute illness, injury, or other medical emergency occurring during school hours or while the student is participating in school-sponsored activities, events, or transportation.

This authorization includes, but is not limited to, the authority to consent to medical examinations, diagnostic testing, anesthesia, surgical procedures, hospitalization, or other treatment as deemed necessary by a licensed healthcare provider.

I understand and agree that any and all costs incurred as a result of such emergency medical care, including ambulance services, physician fees, hospital charges, or other related expenses, shall remain the sole responsibility of the student's parent(s) or legal guardian(s). Neither the Ector County Independent School District nor any of its officers, employees, or agents shall assume financial responsibility for such expenses.

Parent/Guardian Printed Name

Parent/Guardian Signature

Date