

Doss CCSD
Medical Permission Form

STUDENT INFORMATION

Name _____ Grade _____ DOB _____ Male/Female

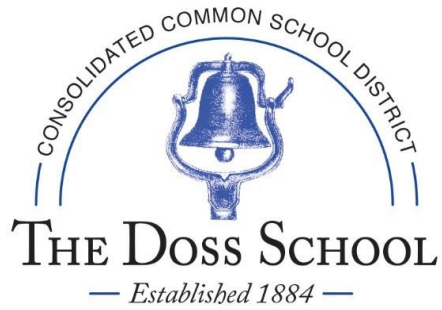
Primary Address: _____

Home Phone _____ Mobile Phone _____

PARENTAL CONSENT

The undersigned does hereby give permission for my child, _____ (child's name), to travel to Fredericksburg ISD in order to receive both a hearing and vision screening test from the Fisd school nurse. These screenings will be free of charge and transportation to and from Fredericksburg will be provided by Doss CCSD.

LIABILITY RELEASE: In consideration of Doss CCSD allowing the Participant to participate in school sponsored activities and/or screenings, I, the undersigned, do hereby release, forever discharge and agree to hold harmless Doss Consolidated Common School District, its administrators, teachers, employees, volunteers and board members (collectively herein "Doss CCSD") from any and all liability, claims or demands for accidental personal injury, sickness or death, as well as property damage and expenses, of any nature whatsoever which may be incurred by the undersigned and the Participant while involved in the school sponsored activities. I the parent or legal guardian of this Participant hereby grant my permission for the Participant to participate fully in school sponsored activities, including trips away from the school premises. Furthermore, I, on behalf of my minor Participant, hereby assume all risk of accidental personal injury, sickness, death, damage and expense as a result of participation in school activities involved therein. The undersigned further hereby agrees to hold harmless and indemnify said Doss CCSD for any liability sustained by said Doss CCSD as the result of the negligent, willful or intentional acts of said Participant, including expenses incurred attendant thereto.



MEDICAL TREATMENT PERMISSION: I authorize an adult, in whose care the minor has been entrusted, to consent to any emergency x-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital or emergency care facility. The undersigned shall be liable and agrees to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child or youth pursuant to this authorization.

Student's Name

Date of Birth

Parent/Legal Guardian (please print)

Parent/Legal Guardian Signature

Date