Lorenzo ISD
School Nurse
806-634-5593, ext. 252

Authorization to Secure Emergency Medical Treatment

Lorenzo ISD and its employees have my permission to obtain emergency medical treatment for my child, _____ when I cannot be reached, or a delay in reaching my child could be dangerous for him/her.

Mother/Guardian Name: _____

Home #:_____ Work #:_____
Cell #:_____

Father/Guardian Name: ______

Home #:_____ Work #:_____
Cell #:_____

My insurance provider is: _____

Preferred hospital/treatment center: _____

My child is taking the following medications: _____

_____

My child has the following allergies: _____

_____

☐ I understand that I assume all financial responsibility for any treatment or injuries sustained by my child while he/she is at Lorenzo ISD or any school related activities.

Parent Signature: _____ Date:_____