



THE CANTERBURY EPISCOPAL SCHOOL
 1708 N. Westmoreland Road • DeSoto, TX 75115
 (972) 572-7200

Please Print or Type

Office Use Only
 Date Rec'd: _____
 Grade: _____
 Copy to: LS _____
 MS _____
 US _____

2010/2011 Treatment Consent – Insurance Information

Please Provide Student's Full Name

Name (1) : _____ Grade: _____ Birthday: _____ SS #: _____

Name (2) : _____ Grade: _____ Birthday: _____ SS #: _____

Name (3) : _____ Grade: _____ Birthday: _____ SS #: _____

Address: _____

EMERGENCY INFORMATION: _____

Family Physician _____ Physician Phone # _____ Family Dentist _____ Dentist Phone # _____

HOSPITAL of PREFERENCE (in case of emergency): _____

Hospital _____ Address _____

INSURANCE INFORMATION: (Required) _____

Insured Name _____ Group # _____ Policy # _____

Insurance Company Name _____ Insurance Company Address _____ Insurance Company Phone # _____

The insurance will cover my child for the duration of **this school year**, and I understand it is my responsibility to pay for any resulting unpaid fees.

It is expected that in case of accident or emergency that the parent or Legal Guardian will be notified as soon as possible.

Signature of Parent or Legal Guardian _____ Date Signed _____

EMERGENCY MEDICAL CONSENT: _____

(I) (We) the undersigned, parent(s) / legal guardian(s) of, a minor, do hereby authorize The Canterbury Episcopal School 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 licensed physician/surgeon, whether such diagnosis or treatment is rendered at the office of said physician/surgeon or at a hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required, but it is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment or hospital which has provided treatment to the above-named minor to surrender physical custody of such minor to (my) (our) above-named agent(s) upon the completion of treatment.

Signature of Parent or Legal Guardian _____ Date Signed _____