



THE CANTERBURY EPISCOPAL SCHOOL
 1708 North Westmoreland Road • DeSoto, TX 75115
 972-572-7200 • 972-572-7400 (fax)
 www.thecanterburyschool.org

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

2011 – 2012 TREATMENT CONSENT – INSURANCE INFORMATION

Please Provide Student's Full Name

Name (1) : _____ Grade: _____ Date of Birth ___ / ___ / ___ SS #: _____

Name (2) : _____ Grade: _____ Date of Birth ___ / ___ / ___ SS #: _____

Name (3) : _____ Grade: _____ Date of Birth ___ / ___ / ___ SS #: _____

Address: _____

EMERGENCY INFORMATION: _____

 Family Physician Physician Phone # Family Dentist Dentist Phone #

HOSPITAL 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 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 a 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 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