

Authorization for Medical Attention

I authorize the facility Director or person in charge to take my child to the nearest facility (HEB Hospital) at 1600 Hospital Parkway Bedford TX, 817-685-4000

Children's Primary Physician Name: _____

Address: _____

Phone Number: _____

I hereby give consent for emergency treatment when my child is in the care of this facility/Hospital/Clinic

Parents Signature Date

CHECK ALL THAT APPLY:	I hereby give do not give		- consent for my child to be transported and supervised by the operation's employees:	
1. TRANSPORTATION:				
Walk home	for emergency care	on field trips	to and from home	to and from school
2. FIELD TRIPS:	I hereby give do not give		- my consent for my child to participate in Field Trips:	
Parent's Comments:				
3. WATER ACTIVITIES:	I hereby give do not give		- my consent for my child to participate in Water Activities:	
	sprinkler play	splashing/wading pools	swimming pools	water table play

Parent/Guardian Signature Date

Vision:	R 20/_____	L20/_____	<input type="checkbox"/> Pass	<input type="checkbox"/> Fail
Signature	_____			
Hearing:	1000Hz	2000Hz	4000Hz	<input type="checkbox"/> Pass <input type="checkbox"/> Fail
Right:	_____			
Left:	_____			
Signature:	_____			

Mid-Cities Scholars requires applications to be verified and/or updated every 6 months

Parent/Guardian Signature

Date