

EXHIBIT E

SPRING BRANCH INDEPENDENT SCHOOL DISTRICT
MEDICAL AUTHORIZATION FORM FOR TRIPS

This section is to be completed by Trip Sponsor:

This document will be presented to appropriate personnel at such time as emergency medical, dental, surgical care, or hospitalization may be required.

Closest medical facility to event: _____

Address: _____ Phone: _____

I / We, being the parent(s) or legal guardian(s) of _____, a minor, do hereby appoint an agent of SBISD from _____ School
Campus

to act in my/our behalf in authorizing emergency medical, dental, or surgical care and hospitalization for the above-named minor during a period of my absence. This authorization is given with my/our understanding that attempts will be made to contact me/us prior to the administration of treatment for any nonlife-threatening situation/condition utilizing the contact information that I/we have provided.

Signature of parent or guardian

Date

Address

City/State/Zip

Home phone

Daytime phone
(Where you can be reached during the trip)

Hospitalization Coverage for the Above-Named Minor

Name of insurance company or government center

Identification or group number

Family physician's name

Family physician's phone number

Insurance Waiver Statement

(Complete this section if you do not have insurance)

Where no proof of insurance is established, it is understood that the parents of the student must assume legal responsibilities for expenses incurred for injuries to students that occur during cocurricular activities. I have read and understand the above.

Signature of parent or guardian

Date

Student's name

Teacher