Kansas State School for the Blind

Extended School Year 2022

FORM A

Authorization for Treatment of Participant and Consent, Release, and Covenant

The undersigned parent/guardian represents to the Kansas State School for the Blind that the minor named below is in his and/or her legal custody and control; and that the undersigned desires said minor to participate in the programs of the Kansas State School for the Blind and that for purposes of said participation the undersigned agrees, authorizes and states as follows:

In case of medical or dental need or emergency, I (we) understand every effort will be made to contact parents/guardians of minors. In the event I (we) cannot be reached, I (we) undersigned, parents/guardians of *insert student name here, a minor, do hereby authorize the Kansas State School for the Blind and its employees as agent(s) for the undersigned to obtain and consent to any X-ray examination, anesthetic, medical, dental, surgical diagnosis, treatment and hospital care which is deemed advisable by, and is to be rendered to said minor under general or specific supervision of any surgeon licensed under the provision of the Medical Practice Act or the medical staff of a licensed hospital or by a dentist licensed under the provisions of the Dental Practice Act, whether such diagnosis of treatment is rendered at the office of said physician or dentist or at the said hospital.

I (we) also understand and agree that any and all such medical, dental, hospital or similar expenses incurred in the treatment of my (our) child will be borne by myself (ourselves). We understand that no representation of such coverage exists or is intended by this form.

It is understood that this authorization is given in advance of any specific medical or dental diagnosis, treatment or care being required but is given to provide authority and power on the part of the Kansas State School for the Blind (as aforesaid) as my (our) agent(s), to give specific consent to any and all such diagnosis, treatment or care which a licensed physician or dentist in the exercise of his/her best judgment may deem necessary.

This authorization shall remain effective while the minor is enrolled in any Kansas State School for the Blind program, unless sooner revoked in writing and delivered.

Participant Name: _____

Parent/Guardian Name: _____

Signature (Parent/Guardian if **under** 18 years of age): _____

Date: _____