***Must be completed and submitted by all students**

Medical Information and Authorization For Treatment

Student Name:_____ Birth date_____

Emergency Phone Numbers: People to notify in case of an emergency and/or pick up.

Father: _____

Work_____ Cell Phone_____ Home_____

Mother: _____

Work_____ Cell Phone_____ Home_____

Other Emergency Contact:_____ Relationship_____

Work_____ Cell Phone_____ Home_____

To Whom It May Concern:

I hereby give my consent to any emergency facility and physician to administer necessary treatment to my child, _____, in the event of an emergency at which time I cannot be reached. I give consent to transport by ambulance if the situation warrants. I grant permission to the school personnel to put band-aids on cuts, administer ice on a bruise or cut, put my child on a cot if sick, and take my child's temperature.

Name of Family Physician_____ Telephone_____

Date of Last DPT or Tetanus_____

Hospital Preference_____

Health Insurance Company_____

Policy Number_____Phone_____Expiration Date_____

1. Check if student has or has had any of the following. Please explain any positive answers.

____Asthma	____Rheumatic Fever	____Scarlet Fever	___Bladder Problems
____Heart Trouble	____Contact Lenses	____Diabetes	___Epilepsy/Convulsions

Explanations_____

_____

2. Is the student on any continuous medication?_____ Specify._____

3. Does your child have any allergies?_____ If yes, please explain._____

_____

4. Is there any other medical information which you feel we should have about your child?_____

_____

_____

Parent/Guardian's Signature

_____

Printed Name

Notarization Required:

State of Florida County of Pinellas The foregoing instrument was acknowledged before me on _____, by _____, who is personally known to me or who has produced_____ as identification.

Name of Notary_____ Stamp or Seal

Notary Public