AUTHORIZATION FOR MEDICAL TREATMENT

Student Name___________________________________ Grade_____
School Year_____________________

We, the undersigned, as the parents and/or guardians of ________________________, hereby consent to any and all emergency medical treatment, including anesthesia and surgical procedures, which may be deemed advisable by qualified physicians selected by agents or officials of Holy Nativity Episcopal School. The intention thereof is to grant authority to administer and to perform examinations, treatments, anesthesia, surgical procedures, and diagnostic procedures, which may now, or during the course of the patients care, be deemed advisable or necessary by qualified physicians.

STUDENT'S ADDRESS ____
PHONE ______________________________

PLACE OF BUSINESS/WORK (DAD) ____
PHONE ______________________________

PLACE OF BUSINESS/WORK (MOM) ____
PHONE ______________________________

MEDICAL INSURANCE CO. ____
POLICY # ____________________________
CLAIMS ADDRESS ____

EMERGENCY CONTACT OTHER THAN PARENT _________________________________
PHONE _________________________ RELATION _________________________________

• •

AGE OF CHILD ______WEIGHT_______DATE OF LAST TETANUS SHOT/DPT _________
ALLERGIES (i.e. FOOD, etc.) ____
Is your child allergic to any form of medication or anesthesia? Yes / No
If yes, explain ____
Does your child take any medication? Yes / No
If yes, what is the frequency of dosage? ____

Note: This form when completed will cover the school year and will be used only when a parent or legal guardian cannot be notified and emergency medical attention is needed.

*** * NOTARIZATION REQUIRED * ***

In witness of our consent and agreement to the matters stated above, we have subscribed our signature below.

DATE_____________ ______________________________________ ____________________________________
PRINTED Name of Parent/Guardian Signature of Parent/Guardian

STATE OF FLORIDA, COUNTY OF BAY
The foregoing instrument was acknowledged before me by ______________________________________
(name of person acknowledging)
who is personally known to me or who has produced _________________________________ as identification.
(type of identification)

SUBSCRIBED and sworn to, before me, a Notary Public, this _____ day of _______________20____.

My commission expires

____
Notary Public

Revised 2/14/18