



PERMISSION FOR MEDICAL TREATMENT

(parents may not notarize their child's form)



I/We, the undersigned, being the parent, legal next-of-kin, or legal guardian of:

_____ (Student's Name) _____ (Birth Date)

hereby authorize emergency medical treatment for this person beginning August 31, 2017 and continuing through June 30, 2018. I/We acknowledge the liability for medical expenses, hospital expenses or other such charges incurred for such services as may be rendered for or on behalf of my/our child as a result of injury or sickness. I/We will assume financial responsibility for the incurred expenses through the insurance company listed below.

Insurance Company _____ Student's Physician's Name _____
Policy Number _____ Student Home Phone _____
Insurance Company Address _____ Student Social Security # _____

Medication and/or food allergies, pertinent medical information, scheduled medications:

_____ Parent's Names (please print)

Home Address _____ City, State, ZIP _____

Home Phone _____ Work Phone 1 _____ Work Phone 2 _____

Parent Cell Phone _____ Parent Cell Phone _____

This document will be taken on all chorus trips and functions. It is the responsibility of the parent to see this properly executed and returned to the chorus room.

STATE OF FLORIDA
COUNTY OF SEMINOLE

_____ Parent Signature

Sworn to and subscribed before me this _____ day of _____, 2017, by _____

_____ Notary Public

My Commission Expires:

Personally Known _____ or Produced Identification _____
Type of Identification Produced _____