MEDICAL TREATMENT AUTHORIZATION FORM 2016-2017

To whom it may concern: You may use this authorization form or a photostatic copy thereof as my permission for any medical treatment necessary for my child, _____

He/She is allergic to the following drugs: _____

And has been treated in the past year for the following illnesses: _____

_____

My medical coverage is with (name and address of insurance company):

_____

_____

_____

My Group Number is:_____

My Subscriber Number is:_____

Signed:_____Print Name:_____

Date Signed:_____Relationship to Student:_____

Address:_____

Phone Numbers: Day_____Night_____

NOTARIZATION. Sworn to and subscribed before me this_____day of _____,2_____.

State of _____, County of_____

Notary Public:_____My Commision Expires:_____

FURTHER MEDICAL INFORMATION

Is your child on medication right now? Please list _____

Family Physician:_____Phone #_____

In case of emergency, please contact the following individuals:

Name:_____Phone #_____

Name:_____Phone#_____

To what hospital do you want your child taken?_____