

EMERGENCY TREATMENT FORM

TO WHOM IT MAY CONCERN:

IN CASE OF AN ACCIDENT OR SERIOUS ILLNESS, SCHOOL WILL CONTACT THE PARENT/GUARDIAN. IF THE SCHOOL IS UNABLE TO REACH THE PARENT/GUARDIAN, OR ANY OTHER PERSON DESIGNATED, THEN I HEREBY AUTHORIZE THE SCHOOL TO CONTACT MY CHILD'S PHYSICIAN AND/OR MAKE ARRANGEMENTS FOR IMMEDIATE EMERGENCY TREATMENT. PAYMENT OF FEES FOR ALL MEDICAL SERVICES WILL BE THE RESPONSIBILITY OF THE PARENT/GUARDIAN.

STUDENT'S NAME

FAMILY PHYSICIAN'S NAME\*

PHONE NUMBER

MEDICATIONS TAKEN DAILY AND/OR REGULARLY:

ALLERGIES:

HEALTH PROBLEMS:

DATE OF LAST TETANUS SHOT:

Insurance Company covering child:

Policy #

Expiration Date:

STATE OF FLORIDA
COUNTY OF PINELLAS

Signature of Parent/Guardian

Date

The foregoing was acknowledged before me this day of

by

Personally known

OR

Produced identification

ID#

Signature of notary

Notary seal or stamp

\*Please notify the school if physician changes.