

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: \_\_\_\_\_

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Insurance Company covering child: \_\_\_\_\_

Policy # \_\_\_\_\_

Expiration Date: \_\_\_\_\_

STATE OF FLORIDA  
COUNTY OF HILLSBOROUGH

\_\_\_\_\_ 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.