BAY DISTRICT SCHOOLS
EXTRACURRICULAR ACTIVITIES

AUTHORIZATION FOR MEDICAL TREATMENT

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

We, the undersigned as the parents/ guardians of ____hereby consent to any
Student Name
and all emergency medical and surgical treatments, including anesthesia and surgical procedures, which may be deemed advisable by qualified physicians selected by agents or officials of the Bay County School Board. 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 patient's care, be deemed advisable or necessary by qualified physicians.

Medical Insurance Company_______________________________________Policy #__________________________

Address of Insurance Company____________________________________Group #__________________________

Student's Address____Phone #________________Age________

Parent/Guardian____Phone #__________________________

Business____Phone #__________________________

Emergency Contact if Parent/Guardian cannot be reached:______________________________Phone#______________

Is you child presently under medical treatment/taking medication? Yes_____ No_____

If yes, describe:____

Frequency of medication:____

Does your religion prohibit any specified medical procedure? Yes_____ No_____

If yes, describe:____

IN WITNESS of our consent and agreement to the matters stated above, we have subscribed our signatures below:

Date:__________________________ ____
Signature of Parent/Guardian

Date:__________________________ ____
Signature of Parent/Guardian

State of Florida, County of ________________________. Sworn to and subscribed before me this ________________day of

__________________________, 20 ____, by ____________________________________who is personally known to me or who

has produced ____________________________________as identification.

____
Signature of Notary Public

____
Typed, Printed, or Stamped Name of Notary

____
My Commission Expires

____
Notary Public Commission Number

EMS. 895.014