Emergency Medical Release

Please print information

Student's Full Name: _____DOB: _____

Allergies: _____ Medicines Routinely Taken: _____

Name of Custodial Parent (s)/ Legal Guardian (s): _____

Address: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Family Physician's Name/Health Care Resource: _____

Address: _____

Telephone: _____ Hospital Preference: _____

Medical Insurance Company: _____

Policy # _____ Expiration Date: _____

Emergency Contact (if custodial parent/guardian cannot be reached): _____

Home Phone: _____ Cell Phone: _____Work Phone: _____

Sign in the presence of Notary.

I hereby give my consent to any emergency facility and physician to administer necessary treatment to my student

_____, in the event of an emergency at which time I cannot be reached.
(Student's full name)

I give consent to transport by ambulance if situation warrants it. _____
Signature of Custodial Parent/Legal Guardian

STATE OF FLORIDA COUNTY OF _____

The foregoing instrument was acknowledged before me this _____ day of _____ 2016

By _____, who is personally known to me or who has produced
(Name of Affiant)

_____ as identification.
(Type of Identification)

SEAL OF NOTARY

Signed: _____
(Signature of Notary)