Form No. TRNS 00797 Appendix C

THE SCHOOL BOARD OF POLK COUNTY, FLORIDA
MEDICAL TREATMENT AUTHORIZATION FORM

TO WHOM IT MAY CONCERN:

I the undersigned parent/guardian of ___________________________________hereby authorize any
(Name of Student)
necessary medical treatment for this student while participating in field trips conducted under the

sponsorship of _______________________________, during the __________________ school year,
(Name of School) (Year)
and guarantee payment of all charges incurred as a result of this medical treatment.

INFORMATION:
ALLERGIES TO FOOD, MEDICATION, ETC. (If none, so state.) - __________________________
____
SPECIAL MEDICAL CONDITIONS (If none, so state.) - ___________________________________
____
FAMILY PHYSICIAN - ____
OFFICE ADDRESS - ____________________________________PHONE NO __________________
PARENT/GUARDIAN NAME – (Please print) ____
PARENT/GUARDIAN HOME ADDRESS - ____
HOME PHONE ______________________ (Street Address)
WORK PHONE ______________________ ____
(City) (State) (Zip)

_________________________________ ____
(Insurance Company) (Policy No. or Group No.)

PARENT/GUARDIAN SIGNATURE________________________________ DATE _______________

STATE OF FLORIDA, COUNTY OF_________________________
I hereby certify that the foregoing was executed before me this ________ day of ________________ ,
by _____________________________________, who is personally known to me or who has produced
____ as identification and who did (did not) take an oath.

____
Notary Public, State of Florida

THIS FORM IS TO BE USED FOR ALL OUT-OF-COUNTY FIELD TRIPS EXCEPT ATHLETIC ACTIVITIES. THE FORM SHOULD BE COMPLETED PRIOR TO THE STUDENT'S FIRST OUT-OF-COUNTY TRIP AND RETAINED ON FILE FOR THE REMAINDER OF THE SCHOOL YEAR. **THIS FORM IS TO BE TAKEN ON ALL FIELD TRIPS.**