Form No. TRNS 00797 **Appendix D**

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 necessary

medical treatment for this student while participating in field trips conducted under the sponsorship of

Lake Region High School during the 2005-2006 school year and
Name of School

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

___________________________________ ____
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.

English Version 8/00