



MEDICAL TREATMENT AUTHORIZATION FORM

To whom it may concern: You may use this authorization form or a photostatic copy thereof as my permission for any medical treatment necessary for my child, _____

He/She is allergic to the following drugs: _____

And has been treated in the past year for the following illnesses: _____

My medical coverage is with (name and address of insurance company):

My Group Number is: _____

My Subscriber Number is: _____

Signed: _____ Print Name: _____

Date Signed: _____ Relationship to Student: _____

Address: _____

Phone Numbers: Day _____ Night _____

NOTARIZATION. Sworn to and subscribed before me this ____ day of _____, 2____.

State of _____, County of _____

Notary Public: _____ My Commission Expires: _____

FURTHER MEDICAL INFORMATION

Is your child on medication right now? Please list _____

Family Physician: _____ Phone # _____

In case of emergency, please contact the following individuals:

Name: _____ Phone # _____

Name: _____ Phone# _____

To what hospital do you want your child taken? _____