



ALL SAINTS' ACADEMY
MEDICAL TREATMENT AUTHORIZATION FORM, GRADES 6-12
2010-2011

TO WHOM IT MAY CONCERN:

I, the undersigned parent/guardian of \_\_\_\_\_
Name of Student

hereby authorize any necessary medical treatment for this student while participating in field trips or
other school related functions conducted under the sponsorship of All Saints' Academy during
the \_\_\_\_\_ school year and guarantee payment of all charges incurred as a result of
this medical treatment.

Information:

Allergies to food, medication, etc. (If none, please state none)

\_\_\_\_\_
\_\_\_\_\_

Medication currently taking (if on prescription, must have name and directions)

\_\_\_\_\_
\_\_\_\_\_

Pain medication child normally takes for headaches

\_\_\_\_\_
\_\_\_\_\_

Medical Problems (include asthma or anything not mentioned above)

\_\_\_\_\_
\_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Parent/Guardian Name, Please Print \_\_\_\_\_

Address (Parent/Guardian) \_\_\_\_\_

Phone- Day (\_\_\_\_\_) \_\_\_\_\_ Home (\_\_\_\_\_) \_\_\_\_\_

Mobile (\_\_\_\_\_) \_\_\_\_\_ Whose? \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Policy/Group # \_\_\_\_\_

Insured's Name \_\_\_\_\_

Student's Social Security # \_\_\_\_\_

Parent/Guardian Signature (sign in presence of notary)

\_\_\_\_\_ Date

State of Florida, County of \_\_\_\_\_

I hereby certify that the foregoing was executed before me this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
Notary Public, State of Florida

\_\_\_\_\_  
Commission Expires