POLK STATE LAKELAND GATEWAY TO COLLEGE COLLEGIATE HIGH SCHOOL
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

_____during the_____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