# EMERGENCY TREATMENT FORM

TO WHOM IT MAY CONCERN:

IN CASE OF AN ACCIDENT OR SERIOUS ILLNESS, SCHOOL WILL CONTACT THE PARENT/GUARDIAN. IF THE SCHOOL IS UNABLE TO REACH THE PARENT/GUARDIAN, OR ANY OTHER PERSON DESIGNATED, THEN I HEREBY AUTHORIZE THE SCHOOL TO CONTACT MY CHILD'S PHYSICIAN AND/OR MAKE ARRANGEMENTS FOR IMMEDIATE EMERGENCY TREATMENT. PAYMENT OF FEES FOR ALL MEDICAL SERVICES WILL BE THE RESPONSIBILITY OF THE PARENT/GUARDIAN.

_____
STUDENT'S NAME

_____ _____
FAMILY PHYSICIAN'S NAME* PHONE NUMBER

MEDICATIONS TAKEN DAILY AND/OR REGULARLY: _____

ALLERGIES: _____

HEALTH PROBLEMS: _____

_____

DATE OF LAST TETANUS SHOT: _____

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Insurance Company covering child: _____

Policy # _____ Expiration Date: _____

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STATE OF FLORIDA
COUNTY OF PINELLAS

_____ _____
Signature of Parent/Guardian Date

The foregoing was acknowledged before me this _____ day of _____, _____

by _____.

Personally known _____ OR Produced identification _____
ID# _____

_____
Signature of notary

Notary seal or stamp

*Please notify the school if physician changes.