Form No. TRNS 00797 **Appendix C**

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
(Name of Student)
necessary medical treatment for this student while participating in field trips conducted under the

sponsorship of _____, during the _____ school year,
(Name of School) (Year)
and 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) (State) (Zip)

_____ _____
(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 Notary Seal

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. **THIS FORM IS TO BE TAKEN ON ALL FIELD TRIPS.**