CONSENT FOR MEDICAL TREATMENT

(Required for students when participating in athletics, student activities, and any field trips that are outside Monroe County)

_____ _____

SCHOOL DATE

The patient and others whose signatures are attached below do hereby consent to any and all medical and surgical treatments including anesthesia and operations, which may be deemed advisable by physician and surgeons. The intention hereof being to grant authority to administer and to perform all and singularly any examinations, treatments, anesthetic, operations and diagnostic procedures, which may now, or during the course of the patient's care be deemed advisable or necessary. We also agree that the patient when admitted is to remain in the hospital until a physician recommends the patient's discharge.

In witness of our consent and agreement to the matters stated in the three preceding sentences, we have subscribed our signatures below.

_____

Minor - Patient

_____

Father

_____

Mother

_____

Guardian(s)

_____

Date

STATE OF FLORIDA)
)SS
COUNTY OF_____)

Sworn to and subscribed before me this_____day of _____, in the year of the Lord _____.

_____

Notary Public
State of Florida at Large

My Commission expires_____

**** If there are any specific medical practices which are prohibited in regards to religious convictions please list below:

MONROE COUNTY STUDENT MEDICAL INFORMATION & PERMISSION FORM

SCHOOL: _____ **SCHOOL PHONE #** _____

Policy and procedure in the event a child requires medical treatment while on any school sponsored trip is to contact the parents to advise them of the situation and obtain consent and direction on how to proceed. In the event of an emergency, and should we be unable to reach you, your signature below would grant permission for routine emergency treatment.

INSURANCE INFORMATION

Student's Full Name: _____

Health insurance Carrier: _____ Policy # _____

I agree that in the event emergency treatment is provided for my child, I will pay any transportation or medical expenses not covered by my insurance company or if I do not have insurance, I agree to pay all such expenses incurred.

IMPORTANT MEDICAL INFORMATION

Please check all that apply:

_____Heart Disease _____Diabetes _____High Blood Pressure _____Epilepsy

_____Allergies _____Other (please list below) _____Medication/s (please list below)

_____

_____

PARENT/GUARDIAN PHONE NUMBERS

Father: _____ Ph: _____

Mother: _____ Ph: _____

Other: _____ Ph: _____

I/we grant the school staff the right to order emergency medical treatment for my/our child and I/we understand that any and all financial responsibility of such services rests with me/us. Finally, I/we agree to hold harmless the school staff and school program for all actions taken on behalf of my/our child.

_____ _____

Parent(s) / Guardian(s) Signatures (s) Date

***If any program or event requires a student to leave the county, this form and the Consent for Medical Treatment form (MCSD-ADM002) must be executed.**