WINTER HAVEN CHRISTIAN SCHOOL
STUDENT MEDICAL TREATMENT AUTHORIZATION FORM

THIS FORM MUST BE FILLED OUT, NOTARIZED AND TURNED IN EVERY YEAR BEFORE SCHOOL BEGINS

(The hospital considers this form invalid if the date of notary seal is more than one year old.)

Student Name____ Grade________ D.O.B._______/_______/_______

Address____ Home Phone___________________________

Father's/Guardian's Name____ Cell #______________________ Bus. #__________________

Mother's/Guardian's Name____ Cell #______________________ Bus. #__________________

Name of two people to contact if parent is not available:

1.____ Daytime #____

2.____ Daytime #____

Insurance Company____ Policy #____

Family Physician____Address_______________________________Phone #__________________

PAST MEDICAL HISTORY
(Check, giving appropriate information)

____ Asthma ____ Sinusitis ____ Bronchitis ____ Kidney Problems ____ Heart Problems ____ Stomach Problems ____ Dizziness

____ Diabetes ____ Hay Fever ____ Hearing ____ Vision ____ Other: ____

Drugs/Medicines (name) ____

Insect/Stings/Bites ____

Poison Sumac, oak, or Ivy ____

Previous Operations or serious illnesses ____

Any current medications or health problem? (List)____

Special Diet: (Name)____

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In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated above and to follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangements seem necessary.

Parent/Guardian Signature____

The foregoing instrument was signed before me on this _____________________ **day of** ________________________**, 20**____

State of Florida, County of Polk by ____

Personally known ____ **or Produced Identification** ____ **Type of Identification produced** ____

Notary Public Signature ____

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