2023-2024 FIELD TRIP
MEDICAL TREATMENT AUTHORIZATION FORM
(This form must be notarized)

INFORMATION:
ALLERGIES TO FOOD, MEDICATION, ETC. (If none, so state.) _____

_____

SPECIAL MEDICATION CONDITIONS (If none, so state) _____

_____

FAMILY PHYSICIAN: _____

OFFICE ADDRESS: _____ PHONE NO: _____

PARENT/GUARDIAN NAME: _____
(Please Print)

PARENT/GUARDIAN HOME ADDRESS _____
(Street Address)

_____
(City/State)

HOME PHONE _____

WORK PHONE _____

_____ _____
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 _____, _____, 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 FORALL OUT-OF-COUNTY FIELD TRIPS EXCEPT