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

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

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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 produced ______________________ as identification and who did (did not) take an oath.

____
Notary Public, State of Florida

THIS FORM IS TO BE USED FOR ALL OUT-OF-COUNTY FIELD TRIPS EXCEPT