EMERGENCY MEDICAL TREATMENT AUTHORIZATION FOR 2016-2017

If my child, _____, becomes ill or injured at Holy Trinity Lutheran School, or while participating in a school-sponsored activity, I understand that Holy Trinity Lutheran School will (1) Contact me immediately; OR (2) Contact the person(s) I have designated if I cannot be reached. Should the facility be unable to reach me and/or the person(s) designated, they are authorized to contact my child's physician and/or arrange for immediate emergency treatment. The physician and/or medical facility is authorized to administer the emergency treatment necessary to ensure the health and safety of my child.

I will accept responsibility for payment of medical services rendered.

I agree that I am responsible to notify Holy Trinity Lutheran School if any information listed below is modified.

Medical alert information (*i.e.* allergies, medical or handicapping conditions) BE SPECIFIC.

**** Please circle the allergy and/or condition that requires medication for treatment. ****

FOOD ALLERGIES (NOT DISLIKES)	ENVIRONMENTAL ALLERGIES	MEDICINE ALLERGIES	CONDITIONS / DIAGNOSIS

My child takes medication regularly (non-school hours included): Name of Medication: _____

Dosage_____ Prescribing Physician AND Phone #: _____

Are child's immunizations up-to-date per State of Florida guidelines? ___ Yes ___ No If No, why? _____

Preferred Physician _____ Phone _____

Address/City/Zip_____

Preferred Hospital_____ Location_____

Insurance Company_____

Name Address Phone

Insured's Name_____ Group #_____ Policy #_____

Parent/Guardian Signature _____ Date_____

NOTARY PUBLIC Sworn to and subscribed before me this _____, day of _____, 20 _____.

_____ who is/are personally known to me _____ who has/have produced identification: _____

Notary Public, State of Florida – At Large.

Notary Signature: _____ My Commission Expires: _____