

**BAY DISTRICT SCHOOLS
EXTRACURRICULAR ACTIVITIES
AUTHORIZATION FOR MEDICAL TREATMENT**

This form when completed will cover the school year. Update of information will be the responsibility of the parent or guardian.

Note: This form will be used only when a parent or legal guardian cannot be notified and emergency medical attention is needed.

We, the undersigned as the parents/ guardians of _____ hereby consent to any _____
Student Name
and all emergency medical and surgical treatments, including anesthesia and surgical procedures, which may be deemed advisable by qualified physicians selected by agents or officials of the Bay County School Board. The intention thereof is to grant authority to administer and to perform examinations, treatments, anesthesia, surgical procedures, and diagnostic procedures which may now, or during the course of the patient's care, be deemed advisable or necessary by qualified physicians.

Medical Insurance Company _____ Policy # _____

Address of Insurance Company _____ Group # _____

Student's Address _____ Phone # _____ Age _____

Parent/Guardian _____ Phone # _____

Business _____ Phone # _____

Emergency Contact if Parent/Guardian cannot be reached: _____ Phone# _____

Is your child presently under medical treatment/taking medication? Yes _____ No _____

If yes, describe: _____

Frequency of medication: _____

Does your religion prohibit any specified medical procedure? Yes _____ No _____

If yes, describe: _____

IN WITNESS of our consent and agreement to the matters stated above, we have subscribed our signatures below:

Date: _____
Signature of Parent/Guardian

Date: _____
Signature of Parent/Guardian

State of Florida, County of _____. Sworn to and subscribed before me this _____ day of _____, 20____, by _____ who is personally known to me or who has produced _____ as identification.

Signature of Notary Public

Typed, Printed, or Stamped Name of Notary

My Commission Expires

Notary Public Commission Number