Trips

ANNUAL PERMISSION FORM FOR MEDICAL TREATMENT

School Board of Broward County, Florida

I, the undersigned, being the parent or legal guardian of ___________________________ ________________,hereby authorize any necessary treatment for my child while on a trip with Coral Glades High School Music Department throughout the 2009-2010 school year.

I also guarantee payment of all charges incurred during this medical treatment.

Parent/Guardian Name (please type or print): _______________________________________

Address: ____ City:_________________________

Telephone/Home: _________________________________ Work ________________________

Telephone/Emergency: ____

Adult to notify in case of emergency if parent/guardian cannot be reached:

Name: __________________________________Telephone(s): ___________________________

In regard to the above named student, the following information is submitted:

1. Allergies to foods, medications, etc.:
   ____
2. Special medical problems:
   ____
3. Currently on medication? List name and dosage:
   ____
4. Date of last Tetanus Shot:
   ____
5. Name/Phone Number of Family Physician:
   ____

Insurance Information

(Please check and complete either part A or part B, whichever is applicable.)

___ **A.** My child is covered by 24-hour student accident and medical insurance.

Insurance Co. Name:___________________________ Policy #:__________________________

Attached is a copy of our family insurance card.

___ **B.** I do not have insurance; however, I will pay any and all medical bills for emergency care of my child.

____ _________________________

Parent/Guardian Signature Date

NOTARY SEAL ____

Notary Signature

Received at Coral Glades High School: By: :_________________Date: _____________________