

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 2010-2011 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: _____