

WINTER HAVEN CHRISTIAN SCHOOL

STUDENT MEDICAL TREATMENT AUTHORIZATION FORM

**THIS FORM MUST BE FILLED OUT, NOTARIZED AND TURNED IN
WITH COMPLETED APPLICATION AND ALL NECESSARY FORMS**

Student Name: _____ Grade: _____ DOB: _____

Address: _____ Cell/Home phone: _____

Father's/Guardian's Name: _____ Cell #: _____

Mother's/Guardian's Name: _____ Cell #: _____

Name of two people to contact if parent isn't available:

1. _____ Cell #: _____

2. _____ Cell #: _____

Insurance Company: _____ Policy #: _____

Family Physician: _____ Phone #: _____

PAST MEDICAL HISTORY

(CHECK THOSE THAT APPLY)

☐ Asthma ☐ Sinusitis ☐ Bronchitis ☐ Kidney Problems ☐ Heart Problems ☐ Stomach Problems
☐ Dizziness ☐ Diabetes ☐ Hay Fever ☐ Hearing ☐ Vision Other: _____

Drug/Medication Name: _____

Insect Stings/Bites: _____

Poison Sumac, Oak or Ivy: _____

Previous operations or serious illnesses: _____

Any current medications or health problems? _____

Special diet: _____

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated above and to follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangements seem necessary.

Parent/Guardian Signature: _____

The foregoing instrument was signed before me on this _____ day of _____, 20_____

State of Florida, County of Polk by _____

Personally known _____ or Produced identification _____ Type of identification produced _____

Notary Public Signature _____

NOTARY SEAL