AUTHORIZATION TO CONSENT FOR MEDICAL TREATMENT

I(we)_____ and _____ of
(parent) (parent)

_____, _____County, _____ do hereby state that I am (we are) the
(city) (county) (state)

natural parent(s), legal guardian(s) having legal custody of_____, a minor,
(minor child)

age ____, born__ _____, resides with me(us) at_____.
(date of birth) (street) (city) (state) (ZIP)

I authorize the administrator or any adult employee of Washington County Christian School, to consent to any x-ray, examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care, to be rendered to the minor under the general special supervision and on the advice of a physician or surgeon licensed to practice in the state of Florida and/or Alabama when the need for such treatment is immediate and when the efforts to contact me(us) are unsuccessful.

Dated this_____ day of _____, 20_____.

_____ _____
(Signatures of parent/guardian) (Signatures of parent/guardian)

THIS FORM IS VALID FOR ONE YEAR FROM DATE OF COMPLETION

FRONT

BACK

Child's Doctor_____

Child's Allergies (if any) _____

Medications_____

Insurance Company_____Insurance Number_____

State of Florida
County of Washington

I hereby certify that on this day, before me, an officer duly authorized in the state aforesaid and in the county aforesaid to take acknowledgements, personally appeared _____, to me known to be the person(s) that (s)he executed the same for the proposed therein expressed.

Witness my hand and official seal in the county and state aforesaid this _____ day of_____, 20 _____.

My Commission expires:

_____
(Notary public)

Individual personally known to me___ Identification shown___ Did not take oath___ Did take oath___