Central Baptist Christian School

402 E. Windhorst Road, Brandon, FL 33510 (813) 689-6133 Fax (813) 689-0011

AUTHORIZATION FOR MEDICAL TREATMENT
2019-2020

TO WHOM IT MAY CONCERN:

In the event of a medical emergency involving my student, at which time I am not present, with the understanding that an attempt to contact me will be made, I hereby give my consent to any emergency facility and/or properly licensed and practicing physician, nurse practitioner, paramedic, EMT, LPN, RN, as well as first responder and staff trained in CPR, BBP, and first aid, to administer treatment to:
my student, ____. Further, I hereby give my consent to transport my student by ambulance if deemed necessary by personnel in charge. **I agree to pay all medical and ambulance expenses.**

Name of Student's Physician ____ Telephone________________

Allergies of Student____

Date of Last DPT or Tetanus____

<u>THE BELOW INSURANCE INFO* IS REQUIRED</u>

(<u>We cannot notarize this form or accept the application without this information or Waiver signature)</u>:

***Name of Insurance Company (Medical)** ____

***Policy Number**_______________________________**Expiration Date**______________________________

<u>Waiver</u>: As Parent/Legal Guardian, I do not carry medical insurance for this student. I agree to hold harmless Central Baptist Church & Christian School from any and all claims, liabilities, and costs that may arise from injury or illness incurred while he/she is enrolled as a student. __________________________________

(Waiver Signature)

EMERGENCY PHONE NUMBERS

Father's Place of Employment____

Father at Work: ______________________Ext._____ At Home:___________ Mobile:____________

Mother's Place of Employment____

Mother at Work: ______________________Ext._____ At Home:___________ Mobile:____________

Other ________________________________Ext.____ At Home:___________ Mobile:____________

____

Parent's /Guardian's Signature

NOTARIZATION REQUIRED (Notary is available on campus):

State of Florida - County of Hillsborough

Witness my hand and official seal, this ____________ day of _______________________ , A.D. 20______.

My commission expires________________________________.

____

Notary Public - State of Florida at Large

**We cannot notarize this form or accept the application unless the required insurance information is filled out.*

(Please fill out both sides of this form.)

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MEDICAL INFORMATION
2019-2020

Name____

Birth Date____________________ Entering Grade____________________

1. Check if student has or had any of the following. Give dates of any positive answers.

___ Polio	___ Jaundice	___ Whooping Cough	___ German Measles
___ Fractures	___ Mumps	___ Rheumatic Fever	___ Measles
___ Tuberculosis	___ Chicken Pox	___ Scarlet Fever	___ Other
___ Malaria	___ Concussion/Head Injury	___ Kidney Infection	___ ADHD/ADD

Explanations____

____

2. Check if student has any of the following. Please explain any positive answers.

___ Asthma	___ Abdominal Pains	___ Tonsillitis
___ Ear Trouble	___ Hearing Loss/Defect	___ Bladder Problem
___ Heart Trouble	___ Contact Lenses/Glasses	___ Epilepsy
___ Diabetes	___ Irritable Bowel Syndrome	___ Hernia

Explanations____

____

3. Is the student on any medication: ___Yes ___No
   Specify____

4. Does your student have any physical limitations which might require some adjustment to a normal student activity schedule? ___ Yes ___No
   If yes, please describe____

5. Has your student had any surgical procedures (major or minor)? ___Yes ___No
   If yes, please describe____

6. Does your student have any allergies? ___Yes ___No
   If yes, please describe____

7. Has your student ever been treated for any nervous, mental, or emotional disorder? ___Yes ___No
   If yes, when and how long a period____

8. Is there any other medical information about your student that you think we should have?
   ____

(Please fill out both sides of this form.)