

THE SCHOOL DISTRICT OF OSCEOLA COUNTY, FLORIDA

MEDICAL AUTHORIZATION FORM

Athletic Department

Student's Name: _____ **Grade:** _____ **DOB:** ___/___/___

I, the undersigned parent/guardian, in the event that I cannot be reached and/or the team is out of the county during an interscholastic event, do hereby authorize the designated SDOC coach or other emergency personnel, if it is deemed necessary, to transport my child to the nearest appropriate healthcare facility and obtain any necessary medical treatment. This authorization is valid for the 2011-12 school year.

I further understand that all expenses and liability for said expenses incurred as a result of this medical treatment shall be fully assumed by me.

Food/ Medication Allergies: _____

Special Medical Conditions: _____

Insurance Company / Policy Number: _____

Date of Last Tetanus Shot (If known): _____

Signature of Parent / Guardian

Phone Number(s)

Witness: _____

Print Name: _____