



**The Schools of McKeel Academy
Medical Treatment Authorization Form**

Student Name _____
Teacher/Grade _____

TO WHOM IT MAY CONCERN:

I the undersigned parent/guardian of _____
(name of student)

necessary medical treatment for this student while participating in field trips conducted under the sponsorship of **McKeel Academy of Technology** during the **2020-2021** school year and guarantee payment of all charges as a result of this medical treatment.

INFORMATION:

ALLERGIES TO FOOD, MEDICATION, ETC. (If none, so state.) _____

SPECIAL MEDICAL CONDITIONS (If none, so state) _____

FAMILY PHYSICIAN _____

OFFICE ADDRESS _____ PHONE NO _____

PARENT/GUARDIAN NAME _____

PARENT/GUARDIAN HOME ADDRESS _____
Please Print

HOME PHONE _____
Street Address

WORK PHONE _____
City

Insurance Company _____
Policy No. or Group No. _____

(Please do NOT write in this box until you are in front of a Notary)

PARENT/GUARDIAN SIGNATURE:	DATE
STATE OF FLORIDA, COUNTY OF	
I hereby certify that the foregoing was executed before me this _____ day of _____ 20 _____,	
by _____, who is personally known to me or who has produced	
As identification and who did (did not) take an oath.	
Notary Public, State of Florida	

This form is to be used for all out-of-county field trips. The form should be completed prior to the students first out-of-county trip and retained on file for the remainder of the school year