The Schools of McKeel Academy Student Name ____________________
Medical Treatment Authorization Form Teacher/Grade ____________________

TO WHOM IT MAY CONCERN:
I the undersigned parent/guardian of ____hereby authorize any
(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 **2021-2022** 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 ____
Please Print
PARENT/GUARDIAN HOME ADDRESS ____
Street Address
HOME PHONE ______________________ ____
WORK PHONE ______________________ City

__________________________________ Policy No. or Group No.________________________
Insurance Company

(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 herby 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