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 **2023-2024** 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