NORTH FLORIDA SCHOOL OF SPECIAL EDUCATION

AUTHORIZATION FOR MEDICAL TREATMENT

1. I am the father/mother/guardian of the minor child below:

   NAME OF CHILD _____ DATE OF BIRTH _____

2. The child resides with me at _____

   Number Street

   _____

   City State Zip Code

Authorization for Emergency Care:

In case of accident or serious illness, and North Florida School of Special Education, hereafter referred to as NFSSE, are unable to reach me, I hereby authorize NFSSE to contact the physician indicated below and follow his or her instructions: If it is impossible to contact this physician, the school may make whatever arrangements necessary to provide care and treatment for my child.

In case of accident/serious illness where the immediate treatment of my child is not necessary, but he/she is unable to remain at the school, the staff will contact me or arrange transportation for my child. If the school is unable to reach me, I authorize NFSSE to contact one of the persons indicated on their enrollment form and ask them to pick up and transport my child home.

3. The child is covered (if applicable) under the following medical plan:

   _____

   Employer Insurance Company Plan Number

4. The child's doctor is:

   _____

   Name Address Phone Number

5. The child's dentist is:

   _____

   Name Address Phone Number

6. Medications taken by child is (list name, dosage and frequency):

   Home: _____

   School: _____

7. Allergies: _____

8. Topical over the counter medications which may be administered by the School. Please check the medications permitted.

   ☐ Neosporin ointment ☐ Benedryl (topical) ☐ Hydrocortisone Cream ☐ Bactine Spray

General Release of Liability:

In consideration of being allowed to participate in any way at NFSSE and related events an activities the undersigned agrees to:

I acknowledge and fully understand that each participant will be engaging in activities that may involve risk or serious injury, including permanent disability and severe social and economic losses, which might result not only from their actions, inactions, or negligence, but the action, inaction or negligence of others, the rules of play or the condition of the premises or of any equipment used. Further, that there may be risks not known to us or not reasonable foreseeable at this time.

I understand that NFSSE and their employees and agents will exercise reasonable care while my daughter/son is in their custody and care engaging in activities through NFSSE. I agree to hold NSFFE and their employees and agents harmless from any and all liability, which may arise while exercising their duty of care, relating to my daughter/son while attending NFSSE.

Parent/Guardian Signature: _____

STATE OF FLORIDA Sworn to and subscribed before me
COUNTY OF _____ this _____ day of _____, 20___

_____

Notary Public

NFSSE REQUIRED MEDICATION AUTHORIZATION FORM
(Must be completed and signed by a phyisican)

Student name: _____

Date of birth: _____ Age: _____

Allergies: _____

Medical Conditions / Diagnosis: _____

_____

Daily medications to be given at school. Include as needed medication such as Tylenol and Motrin, which MUST be provided by the parent. All medications must be in their original container and labeled with the student's name.

Medication: _____ Dose: _____ Route: _____ Time: _____

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Medication: _____ Dose: _____ Route: _____ Time: _____

Medication: _____ Dose: _____ Route: _____ Time: _____

Emergency medications to be given at school:

Medication: _____ Dose: _____ Route: _____

To be given when: _____

Other emergency instructions: _____

Medication: _____ Dose: _____ Route: _____

To be given when: _____

Other emergency instructions: _____

Signature of Healthcare Provider: _____ Date: _____

Title: _____

Parent signature and printed name: _____