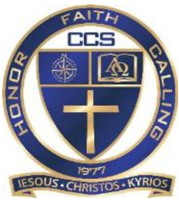

MEDICAL AUTHORIZATION AND RELEASE

Please note that this form must be notarized when signed

I/We, the undersigned, do hereby consent to, authorize and direct the officials of the Community Christian School, Tallahassee, Florida to obtain for ____
such medical care, treatment or hospitalization as may be necessary while said individual is attending any outing sponsored by or in transit to or from Community Christian School during the school year.

I/We, the undersigned, do hereby release, remise, and forever discharge the officials and Community Christian School of Tallahassee, Florida from any and all claims, demands, actions or cause of action, past, present or future arising out of any damage or injury to the above said individual.

Name of youth	
Address	
Phone	Date of last tetanus shot
❖ Does the above named wear contact lenses, glasses, or any other prosthesis ☐ yes ☐ no If yes, specify.	
❖ Is he/she allergic to any medication or serums? ☐ yes ☐ no If yes, specify.	
❖ Is he/she taking any medication at the present? ☐ yes ☐ no If yes, specify.	
❖ Is there any medical background which would be of importance as to treatment of this person, (epileptic, asthmatic, diabetic, etc.)? ☐ yes ☐ no If yes, specify.	

Health Insurance Provider___________________________________ Insurance #________________________

State of Florida County of _____________. Commission Expires ___________________

Personally known to me______ Produced Identification ______ Type of identification produced ____________

Dated this ________ day of _____________ 20__.   ____
Parent or guardian signature

____   ____
Notary signature   Parent or guardian signature