LAKE WALES CHARTER SCHOOLS, INC.
MEDICAL TREATMENT AUTHORIZATION FORM
OUT OF COUNTY FIELD TRIPS

TO WHOM IT MAY CONCERN:

I the undersigned parent/guardian of ______________________________ hereby authorize
(Name of Student)
any necessary medical treatment for this student while participating in field trips conducted

under the sponsorship of _______________________________ during the ______________
(Name of School)
school year and guarantee payment of all charges incurred 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 ____
Home Phone _______________ Street Address
Work Phone _______________ ____
City

____ _______________________________
Insurance Company Policy No. or Group No.

____ _______________________________
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