

KENTWOOD PREPARATORY SCHOOL and CAMP



AUTHORIZATION FOR MEDICAL TREATMENT School Year: 2020-2021

I _____ of (Address) _____

City/Zip _____, do hereby state that I am the parent or legal guardian

of (student's name) _____, born on (DOB) _____.

I hereby authorize a Kentwood Preparatory School, Inc. representative, along with the medical facility of their choice, to act in my capacity and to make any and all decisions regarding the care and treatment of any medical emergency for the above named minor, and to consent to any examination, care, treatment or procedure including, without limitation, surgery, examination, medications, anesthesia and/or hospital care to be rendered to the above named minor under the general or special supervision, and on the advice of any physician or surgeon licensed to practice medicine in the state of Florida. This authorization will remain in effect for as long as my child is enrolled at Kentwood. I agree to notify Kentwood and complete a new form if any of the information below changes.

Allergies to food or drugs _____

Significant med. History (asthma, seizures etc.) _____

Child's physician _____

Insurance Company _____ Policy Number _____

Parent/Guardian Tel: Dad Home _____ Work _____ Cell _____

Mom Home _____ Work _____ Cell _____

Signature of Father _____ Date _____

Signature of Mother _____ Date _____

Signature of Legal Guardian _____ Date _____

NOTARY PUBLIC:

State of Florida, County of:	
Sworn and Subscribed to me on this date:	
Notary Public Signature:	
Printed Name of Notary Public	
My Commission Expires:	
Personally Known to Me:	Produced Identification:
Type of Identification Produced:	
Seal:	