

Inland Lakes Schools

MEDICAL TREATMENT PERMISSION FORM

Student Name _____ Date of Birth _____

Parent /Guardian Name _____ Phone# _____

Address _____

Emergency Contact _____ Phone# _____

Doctor's Name _____ Phone# _____

Current Medication (if any) _____

Emergency Health Factors:

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Aspirin Allergy | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hemophiliac | <input type="checkbox"/> Diabetic |
| <input type="checkbox"/> Multiple Critical Allergies | <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Iodine Allergy | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Special Blood Condition | <input type="checkbox"/> Epileptic | <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Sulfa Allergy |
| <input type="checkbox"/> Bee Sting Allergy | <input type="checkbox"/> Asthma | <input type="checkbox"/> Other | |
- _____

In case of an emergency, or a need for medical attention, I hereby grant my permission for such treatment by a qualified nurse, physician or hospital for my child. I also grant my permission for the necessary information to be released to the insurance company. I will be responsible for all medical expenses incurred.

Parent/Guardian _____ Date _____

Insurance Company _____ Policy Number _____

Date _____

My Commission Expires

Notary Public Signature Line