Medical Release Form

Information on subject of this form:

Full name:_______________________ Address:___________________

Medical Ins. Co. :____________________ Policy or group # _____________

Medical Conditions: ____

Allergies: _______________________Current Medication:_____________

Person to contact in case of an emergency:

Parent/guardian:____

Phone #s:1st__________________others:_________________________

Alternate person to contact if you can not be reached:

Name: _______________________ Phone #s: ____________________

I, who by law may do so, authorize the administration of emergency medical treatment to s/he who is the subject of this form. I understand all reasonable safety precautions will be taken at all times by Woodlawn Community Academy or its staff and I will not hold them liable for any accident, injury or disease of the subject of this form. I understand that in the event that medical intervention is needed every attempt will be made to contact the person(s) above immediately.

_______________________________ ________________

Parent/guardian signature date

State of Florida, County of Pinellas- Before me personally appeared ____________________ Known to me to be the person described in and who executed the foregoing instrument, by presenting their picture indentification of : ________________________and acknowledged to and before me that they executed said instrument for the purposes therein expressed. Witness my hand and official seal, this ___________day of 20________.

Notary Public________________________________