# DR. PHILLIPS HIGH SCHOOL - BAND
## *EMERGENCY TREATMENT AUTHORIZATION CARD*
## 2006-2007 SCHOOL YEAR

**EMERGENCY TREATMENT AUTHORIZATION CARD – English** **SCHOOL BOARD OF ORANGE COUNTY, Florida** **(Please Print)**

Athlete's Legal Name: _____ School: _____ Grade: _____

Athlete's Date of Birth: _____ Date of last tetanus shot: _____

My child is allergic to the following medications: _____

My child has the following allergies: _____

Please identify any serious injuries or illnesses your child has had: _____

Alternate family member/friend to contact in case of emergency: _____

Name: _____ Telephone Number(s): _____

Primary Care Doctor Name: _____ Telephone Number: _____

You understand that the insurance offered by Orange County Public Schools is a secondary policy and will pay only after your personal insurance pays. You also understand that your child is only covered by OCPS sport insurance during the FHSAA specified season.

Primary Insurance Company: _____ Policy Number: _____

Insurance Company Address: _____

You understand if a parent, guardian or student falsifies any signature or information on the emergency medical treatment card, the student will be declared ineligible to participate in any Orange County interscholastic activity for one full calendar year from disclosure date. You further give your permission for appropriate school staff and their designees to render medical treatment or authorize medical treatment by a hospital and/or doctor and agree to hold the School Board and its employees harmless in the administration of such assistance. I hereby acknowledge and certify that I have read the emergency medical document, that I understand and agree with its terms. Florida Statutes (92.525) "Under penalties of perjury, I declare that I have read the foregoing and that the facts stated in it are true." I agree to be bound by its terms and I have reviewed and explained the notice with my child.

_____ _____ _____

Signature of Parent/Legal Guardian | Print Name of Parent/Legal Guardian | Date

Telephone (H) _____ Telephone (W) _____ Other _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

***AUTHORIZATION TO ADMINISTER OVER-THE-COUNTER MEDICATIONS (INITIALS) _____ , (DATE) _____***