

Medical Release 2020-2021

THIS FORM MUST BE NOTARIZED

*Please note. Only sign and notarize Part II if you do NOT want
Emergency medical treatment for your child.*

SCHODL BOARD OF HILLSBOROUGH COUNTY MEDICAL RELEASE FORM

PART I

The undersigned as the parents and/or legal guardians of _____ do hereby consent to any and all medical and surgical treatments, including anesthesia and operations, which may be deemed advisable by any qualified physician selected by agents or officials of the Hillsborough County School Board. The intention hereof is to grant authority to administer and to perform all and singularly any examination, treatments, anesthetics, operations, and diagnostic procedures, which may now or during the course of the patient's care be deemed advisable or necessary by any qualified physician. No action shall be taken until an attempt is made to contact me at the phone number(s) listed below.

Cell: () - _____
Parent/Guardian Name: _____ Business' () - _____

IN WITNESS of our consent and agreement to the matters stated above, we have subscribed our signature below.

Signature: _____ Signature _____

Personally known to me -OR- _____ Personally known to me -OR- _____
___ produced identification Type of identification Driver's License
___ produced identifications Type of identification Driver's License

Identification # _____ Identification # _____
State Issued _____ State Issued: _____

STATE OF FLORIDA, COUNTY OF HILLSBOROUGH COUNTY SUBSCRIBED AND SWORN TO BEFORE ME A NOTARY PUBLIC,
this: _____ 20

(Notary Seal)

My commission expires: _____

Note: Public: _____
(SI nature)

***** (Printed Name) *****

PLEASE DO NOT COMPLETE THIS SECTION IF YOU COMPLETED PART I.

PART II

As parent or guardian of the student listed below, I do not desire to sign the medical and surgical release form above.

Name of Student: _____ Date: _____

Parent or Guardian: _____ Date: _____