

Physician Information:

Name of Student's Physician: _____

Address: _____ Phone: _____

Insurance Coverage:

Insurance Company: _____ Phone: _____

Policy/Group #'s: _____

Other Information Needed: _____

Granted Permission:

I hereby give permission to the physician selected by the adult in charge of the Heritage UMCSM to order x-rays, routine tests and treatment for the health of my child, and in the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the adult in charge to hospitalize, secure proper treatment for and to order injections and/or anesthesia and/or surgery for my child, _____. I agree to hold the adult in charge free and harmless of any claims, demands, or suits for damages arising from the giving of such consent.

I also give my permission for use of photographs/videos taken of my student to be used on the Church website or any other promotional literature.

Parent or Guardian Signature: _____

Must be signed in the **presence** of a notary.

Date signed: _____

STATE OF FLORIDA, COUNTY OF PINELLAS

The foregoing instrument was acknowledged before me this _____ day of _____, 201____, by _____ who is personally known to me or who has produced _____ as identification, and who did not take an oath.

Signature of Notary

Name of Notary (Printed or Stamped)

(Serial Number — if any)

