New Dimensions High School

4900 Old Pleasant Hill Road, Kissimmee, FL 34759

2018-2019

Medical Authorization Form
Athletic Department

Student's Name: _____ Grade Level _____ DOB _____

I, the undersigned parent/guardian, in the event that I cannot be reached, and/or the team is out of the county during an interscholastic event, do hereby authorize the designated SDOC/NDHS coach or other emergency personnel, if it is deemed necessary, to transport my child to the nearest appropriate healthcare facility and obtain any necessary medical treatment.

I further understand that the School Insurance Policy DOES NOT guarantee policy benefits. The Student Insurance Policy is secondary to all other sources of coverage and may not pay 100% of all incurred medical expenses. Any and all expenses and liability for said expenses incurred as a result of this medical treatment shall be fully assumed by me.

---------- ADDITIONAL EMERGENCY MEDICAL AND CONTACT INFORMATION ----------

Food/Medicine Allergies: _____

_____

Special Medical Conditions: _____

_____

Insurance Company and Policy Numbers:

Company Name _____ Policy # _____

Policyholder Name _____ Group # _____

Date of Last Tetanus Shot (if known): _____

This medical authorization is valid for the 20____ - 20____ school year.

Printed Parent/Guardian Name	**Parent /Guardian Signature**	**Date**	**Cell Phone Number**
Printed Name of Witness	**Signature of Witness (Must be of legal age)**	**Date**	**Cell Phone Number**

Print Name / Relationship to Student	**Phone Number 1 (Cell)**	**Phone Number 2**
Print Name / Relationship to Student	**Phone Number 1 (Cell)**	**Phone Number 2**

Original: Athletic Director **Copy: Coach**