New Dimensions High School
4900 Old Pleasant Hill Road, Kissimmee, FL 34759
Tel. 407-870-9949 Fax 407-870-8976

2019-20

MEDICAL AUTHORIZATION FORM ATHLETIC DEPARTMENT

Student's Name: _____ Grade: _____ 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 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.
Contact Information:

_____	_____	_____
Name (print) – Relationship to student	**Cell Phone Number 1**	**Cell Phone Number 2**
_____	_____	_____
Name (print) – Relationship to student	**Cell Phone Number 1**	**Cell Phone Number 2**

_____	_____	_____	_____
Printed Parent/Guardian Name	Parent/Guardian Signature	Date	Cell Phone No
_____	_____	_____	_____
Printed Parent/Guardian Name	Signature of Witness (Must be of Legal age)	Date	Cell Phone No

Original: Athletic Director Copy: Coach