



**Parental Authorization for Treatment of a Minor Child**  
**Minor Medical Information, Consent, and Release of Liability**

Child's Full Legal Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Gender  Male  Female

Child's Home Address \_\_\_\_\_ City & Zip \_\_\_\_\_

Mother's Name \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Father's Name \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Insurance Carrier (photocopy both sides of insurance card & attach) \_\_\_\_\_

Primary Insured Name \_\_\_\_\_ Relationship \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address, City & Zip \_\_\_\_\_

Other Contacts: Please furnish two (2) additional names of people you would feel comfortable with us contacting in the event that you are unavailable.

Emergency Contact #1 \_\_\_\_\_ Relationship \_\_\_\_\_

Cell Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Home # \_\_\_\_\_

Emergency Contact #2 \_\_\_\_\_ Relationship \_\_\_\_\_

Cell Phone # \_\_\_\_\_ Work # \_\_\_\_\_ Home # \_\_\_\_\_

**MEDICAL INFORMATION**

Known Allergies: \_\_\_\_\_

Medical Conditions: \_\_\_\_\_

Additional Needs/Concerns \_\_\_\_\_

**Current Medications:**

Name	Reason	Dosage	Time Administered

Additional Instructions: \_\_\_\_\_

**Medical Consent and Release:** I, the Parent or Guardian, give permission for my child to attend off-site events, sponsored by Florida State University Schools, on and between the dates mentioned. I also understand that every effort will be made to contact me if my child needs medical treatment. If it is impossible to do so, I give my permission to medical personnel selected by the adult leadership to secure proper treatment; to transport, to hospitalize, order injections, anesthetize, x-ray or do surgery for my child. I do hereby release and forever discharge Florida State University Schools from any claim whatsoever that arises or may hereafter arise on account of any first aid, treatment or service rendered in connection with the child's involvement in a Florida State University Schools activity or with the decision by any representative of Florida State University Schools to exercise the power to consent to medical or dental treatment as such power may be granted and authorized in the Parental Authorization for Treatment of a Minor Child.

**Liability Release:** I, the Parent or Guardian, will hold harmless Florida State University Schools and its assigns from any and all liability, claims, and demands of whatever kind or nature, either in law or in equity, which arise or may hereafter arise from the above named child's involvement in any Florida State University Schools activity. This discharges Florida State University Schools from liability or claim with respect to any bodily injury, personal injury, illness, death or property damage that may result from the child's activity with Florida State University Schools whether caused by the negligence of Florida State University Schools or its leaders, teachers, staff or committee members or otherwise. Florida State University Schools does not assume any responsibility for or obligation to provide financial assistance or other assistance, including but not limited to medical or disability insurance, in the event of injury or illness.

**Other:** The Parent or Guardian expressly agrees that this Release is intended to be as broad and inclusive as permitted by the laws of the State of Florida and that this Release shall be governed by and interpreted in accordance with the laws of the State of Florida. The Parent or Guardian agrees that in the event that any clause or provision of this Release shall be held to be invalid by any court of competent jurisdiction, the invalidity of such clause or provision shall not otherwise affect the remaining provision of the Release which shall continue to be enforceable.

Parent/Guardian: \_\_\_\_\_ Date \_\_\_\_\_

(Print Name Clearly)

Parent/Guardian Signature \_\_\_\_\_