

**Medical Treatment Permission Statement
Jupiter Community High School**

I hereby grant permission to administer medical treatment and to release medical information on my child incident to his/her participation in school sponsored activities, practices, performances, and/or travel for a period of one year from the date this day. I will assume financial responsibility for this medical treatment either directly or through insurance.

(Student's Name)

(Parent/Guardian Signature)

Dated this _____ day of _____, 2006

(Notary Public Signature)

Done FREE IN Guidance (SEAL/STAMP)

PLEASE LIST INSURANCE COVERAGE NOW IN EFFECT, EITHER A or B:

A. Personal Insurance

Type of Coverage: _____

Company: _____

Agent: _____

Policy Number: _____

B. School Group Insurance: Yes _____ No _____

Policy Number: _____

Identify any medication the student may be taking: _____

Identify any medical condition of the student, which may need attention: _____

*EMERGENCY #
OR CELL # _____*