WALDEN SCHOOL
Authorization for Emergency Medical Treatment

As parents of ______________________________________ we authorize the treatment by a qualified and licensed medical doctor of our child in the event of a medical emergency which, in the opinion of the attending physician, may endanger the child's life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to contact us.

This consent is valid while the child is in the care of Walden School.

This consent is signed for the sole purpose of authorizing medical treatment under emergency circumstances in our absence.

Mother :______________________ Father ______________________

Address:______________________ Address : ______________________

Home phone:______________________ Home phone:______________________

Work phone:______________________ Work phone:______________________

Other:______________________ Other______________________

Child's Physician : ______________________________________

Telephone : ______________________________________

Specific medical allergies, chronic illnesses or other conditions :

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Other contact in case of emergency :

Name : ______________________________________

Telephone : ______________________________________

StATE OF FLORIDA
COUNTY OF PINELLAS

Before my personally appeared ______________________who produced the following type of identification:______________________________ , or to me well known to me to be the individual described in and who executed the foregoing Authorization for Emergency Treatment and he/she acknowledged before me that he/she executed the same for the purposes therein expressed.

Witness my hand and official seal in the County and State named above this _______day of

______________________, A.D., 2023.

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Notary Public

State of Florida

My Commission Expires: