John Carroll High School
3402 Delaware Avenue
Fort Pierce, FL 34947-6116
772-464-5200 Fax 772-464-5233

If your child will be participating in any event off campus this form needs to be completed, **signed in the presence of a Notary** and returned to the Athletic Director as soon as possible.

Student's Full Name ______________________________

The patient and others whose signatures are attached below do hereby consent to any and all medical and surgical treatments including anesthesia and operations which may be deemed advisable by his or her physicians or surgeons.

The intention hereof being to grant authority to administer and to perform all and singularly any examinations, treatments, anesthetics, operations, and diagnostic procedures which may now or during the course of the patient's care be deemed advisable or necessary. We also agree that this form should be presented in any emergency in which the parents can **not** be reached.

Minor Student/Patient ______________________________

Father/Guardian ______________________________

Mother/Guardian ______________________________

STATE OF FLORIDA
COUNTY OF ______________________________

The foregoing statement was acknowledged before me this __________ day of

______________________ 20 ____, by ______________________________

☐ Personally known to me.

☐ Produced as identification ______________________________
(type of identification)

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Notary Public, State of Florida at Large

______________________________ ______________________________
Parent's/Legal Guardian's Primary Insurance Co. Policy #

MAKSIN MANAGEMENT CORP. POLICY # ______________________________
John Carroll Catholic High School insurance used as secondary coverage.

Allergies or notable physical conditions ______________________________

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Special instructions or limitations by Parents/Legal Guardians ______________________________

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