



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 Notary** and returned to the Athletic Director prior to the first away contest of the season

Student's Full Name: _____ Sex: ____ Age: ____

Date of Birth: ____/____/____

Grade in School Year 2011-2012: ____ Sport(s): _____

Home Address: _____

Home Phone: (____) _____

Name of Parent/Guardian: _____ E-mail: _____

Person to Contact in Case of Emergency: _____

Relationship to Student: _____ Home Phone: (____) _____ Work Phone: (____) _____ Cell Phone: (____) _____

Personal/Family Physician: _____ City/State: _____ Office Phone: (____) _____

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 intentions 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 _____

The foregoing statement was acknowledge before me this ____ day of

_____ 20 ____, by _____

_____ Personally known to me

_____ Produced identification _____

 Notary Public, State of Florida at Large

 Parent's/Legal Guardian's Primary Insurance Co.

 Policy #

Maksin Management Corp. Policy #AMK0000380

John Carroll Catholic High School Insurance used as secondary coverage.

Allergies or notable physical conditions _____

Special instructions or limitations by Parent/Legal Guardians _____