SEMINOLE COUNTY PUBLIC SCHOOLS, FLORIDA

RELEASE AND CONSENT

THIS FORM MUST BE READ AND SIGNED BY PARENT(S) OR GUARDIAN(S) OF EVERY MINOR.

STUDENT NAME: _____
Last **First** **MI**

I/We **do hereby approve of our child attending:** _____

_____

I/We **acknowledge that the Seminole County Public Schools, Florida is not liable for medical expenses, hospital expenses , or other such charges incurred for such services as may be rendered for or on behalf of *my/our* child as a result of injury or sickness. *I/We* understand that if *my/our* child is injured or becomes sick, Seminole County Public Schools, Florida will not be liable unless the injury or illness is the result of negligent conduct on the part of an employee of Seminole County Public Schools, Florida.**

Child's Allergies: _____

PHYSICIAN INFORMATION

Child's Physician: _____

Address of Physician: _____ **Telephone Number:** _____

_____

MEDICAL INSURANCE INFORMATION

Medical Insurance Co.: _____

Address: _____ **Telephone Number:** _____

Policy #: _____ **Group #:** _____

Parent/Guardian Signature: _____ **Date:** ____/____/____

Parent/Guardian Telephone Number: _____ _____
(work) (home)

Emergency Telephone Number: _____ (*and*) **Contact Person:** _____

SCPS FORM 504 (Rev. 9/95)