Community Leadership Academy

3122 Mahan Drive, Suite 801-270 Tallahassee, Fl. 32308 *850-597-9124 phone

Insurance Validation, Medical Authorization, and Notarized Medical Emergency Form 2019-2020

Today's Date: __________________________

Student's Name: ____

Grade: _______________ Date of Birth: ______________________

Address: ____

City: __________________________________ State: ________ Zip: _________

Medical Profile:

Known Illnesses: ____

Known Allergies: ____

Food Restrictions: ____

Has the student been immunized according to Florida state law? Yes_____ No ________
If no, please explain: ____

Does the student have updated Tetanus shots? Yes ______ No ______

Does the student have any physical limitations that might affect his/her ability to participate in planned activities? Limited __________ Not limited _________
If yes, please explain ____

In case of an emergency we will call parents first. In the event parents cannot be reached, please give us a second individual who can authorize medication and pick up your child if necessary:

____

Relationship to student: ____

Address ____

Phone: Home ______________________ Office ______________________

Cell ______________________

Insurance Validation

Medical insurance coverage is encouraged for all students attending Community Leadership Academy. Please fill out your family's insurance information below and sign the Medical Authorization.

☐ **We do not have medical coverage** ☐ **Yes, we have medical coverage**

Name of policyholder ____SSN____________________

Insurance Company _____________________________________Policy Number________________

If Medicaid, number ____

Father's Signature Mother's Signature

Printed Names

DOCTOR: 1st Choice __________________________________ Phone: ___________________

2nd Choice _________________________________ Phone: ___________________

HOSPITAL CHOICE: ____ Phone: _______________

Medical Authorization

I hereby give permission for my child to receive emergency medical attention from a physician or health care facility in the event of illness or injury to my child. Further, I hereby authorize the faculty, staff, and employees of Community Leadership Academy to contact directly the persons named on this form, if necessary for the health of my child, and do authorize the named physicians and health care facility, or any other necessary emergency health care facility, to render such treatment as may be deemed necessary in an emergency for the health of my child. I accept all financial responsibility for all expenses incurred for this medical care.

I understand and acknowledge that in the event I cannot be contacted by school faculty, staff, or employees, then such persons are hereby authorized to take whatever action is deemed necessary in their judgment for the health of my child. I accept and assume full financial responsibility for the emergency care and/or transportation for my child and will not hold the school financially responsible.

____ ________________________

Signature of Parent/Guardian **Date**

Notarized Section of Medical/Insurance Form

On this ________ day of ________________, ________, _________________________________

(date) (month) (year) (name of parent)

personally appeared before me in ___________________ County (in the state of __________)

and, in my presence, signed this medical release form. {Seal Below}

Printed Name of Notary Official:____________________

Signature: ________________________

 Parent initials: __________