Academie Da Vinci Charter School for the Arts
Authorization for Emergency Treatment
1060 Keene Rd.
Dunedin, FL 34698
727-298-2778

Name of Student: _____

In the event that any administrator, teacher, or staff member of Academie Da Vinci determines, in his or her judgment, every reasonable effort will be made to contact the following parents/guardians/ designated persons to inform you of the conditions and needs of your child:

First Contact:_____ Phone:_____

Second Contact: _____ Phone:_____

Third Contact: _____ Phone: _____

In the event that, after reasonable efforts, none of the foregoing persons can be reached, the undersigned parent/guardian of the above-named student does hereby consent to:
(1) The administration of any treatment deemed necessary by:

Dr._____ Phone_____ in a medical emergency: or

Dr. _____ Phone_____ in a dental emergency: or if the appropriate specified practitioner is not available, by another Florida licensed physician or dentist who may be available to provide medical or dental services to the above-named student: and

(2) If required in the judgment of any member of the teaching or administrative staff of Academie Da Vinci, the transfer of the above-named student to: _____ Hospital or any other hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists concurring in the necessity for surgery are obtained in writing prior to the performance of surgery.

The following information concerning the above-named student may be needed by any hospital or practitioner not having access to the student's medical history. Please provide any pertinent data concerning the student for use by any hospital or practitioner who may be called upon to provide treatment:

Allergies:_____

Current Medications: _____ Last Tetanus Shot:_____

Physical Impairments:_____

Other pertinent facts: _____

Signature of Parent or Guardian:_____ Date: _____

Health Insurance Co._____ Policy#:_____