School District of Hillsborough County
MEDICAL RELEASE FORM

***Name of Student*:**____

Name of Parent:____

Parent home phone:____________________***Parent business phone:***_________________***Parent cell phone:***____________________

PART I (ONLY COMPLETE PART I OR PART II)

The undersigned as the parents and/or legal guardians of ____ do hereby consent to any and all medical and surgical treatments, including anesthesia and operations that may be deemed advisable by any qualified physician selected by agents or officials of the Hillsborough County School Board. The intention hereof is to grant authority to administer and to perform all and singularly any examination, treatments, anesthetics, operations, and diagnostic procedures that may now or during the course of the patient's care, be deemed advisable or necessary by any qualified physician. **No action will be taken until an attempt is made to contact me at the phone number(s) listed above**.

IN WITNESS of our consent and agreement to the matters stated above, we have subscribed our signature below.

Signature of parent or guardian:______________________________________Date:________________________________

STATE OF FLORIDA
COUNTY OF HILLSBOROUGH
SUBSCRIBED AND SWORN TO BEFORE ME A NOTARY PUBLIC, THIS ____________ DAY OF ______________________ 20____________.

My Commission expires:____

Notary Public:____

PART II (ONLY COMPLETE PART I OR PART II)

As parent or guardian of the athlete listed below, **I do not desire** to sign the medical and surgical release form above.

Signature of parent or guardian:____Date:________________________________

(Do not sign both parts. This form does not need to be notarized if Part II is signed.)