



Student VID: _____
Campus: W E O
Cohort: BR 2020

PERMISSION FOR MEDICAL SERVICE

I hereby give my consent for the Valencia College staff or their designees to render emergency treatment or authorize medical treatment by a hospital and/or doctor(s) associated with injury for me/my child _____. I understand I am to assume all financial responsibilities for any medical services rendered. I agree that Valencia College and staff are not liable in the event such emergency assistance is necessary.

Medical Insurance Company _____

Address _____

Subscriber Name _____ Policy # _____ Group # _____

Emergency contact information:

Contact name (s) _____

Relationship to student _____

Telephone numbers _____

Parent / Guardian Signature

Date

Student Signature

Date