



**SCHOOL OF NURSING
MEDICAL RELEASE**

INSTRUCTIONS: To be completed by ALL students. This **MUST BE** signed in the presence of a notary. An ID must be provided.

Patient Name: _____ Date: _____

I grant permission to the Health Department or the local hospital or medical doctor to render emergency treatment to me that might be deemed necessary.

I understand that I am responsible for any costs incurred and the College is not financially obligated.

Signature of student, parent or guardian
(In ink in the presence of Notary Public)

Sworn and subscribed to me this ____ day of _____, 20

State of Florida, County of _____

Signature of Notary Public