MEDICAL RELEASE FORM

LAST NAME_____FIRST NAME_____ D.O.B._____
PARENT/GUARDIAN NAME_____ HOME PHONE_____
HOME STREET ADDRESS_____
CITY_____ STATE_____ ZIP CODE_____
MOTHER'S WORK PHONE_____CELL PHONE_____
FATHER'S WORK PHONE_____CELL PHONE_____

IN CASE OF EMERGENCY AND PARENT IS NOT AVAILABLE CONTACT:

NAME_____ADDRESS_____
PHONE_____ ALT PHONE _____
RELATIONSHIP TO STUDENT_____

NAME_____ADDRESS_____
PHONE_____ ALT PHONE _____
RELATIONSHIP TO STUDENT_____

PROFESSIONAL CONTACTS:
STUDENT'S PHYSICIAN_____PHONE_____
STUDENT'S DENTIST_____PHONE_____
HOSPITAL STUDENT SHOULD BE TAKEN IF PARENT OR PHYSICIAN UNAVAILABLE

ALLERGIES & MEDICAL CONDITIONS (Please explain checked items below. If necessary, use other side.)
__ALLERGIES __ASTHMA __DIABETES __OTHER
__EPILEPSY __HEART PROBLEMS __RECURRING/CHRONIC ILLNESS
_____
_____

MEDICATIONS: (LIST ALL MEDICATIONS STUDENT TAKES REGULARLY INCLUDING OVER-THE-COUNTER MEDS)
MEDICINE_____ DOSE_____FREQUENCY_____
MEDICINE_____ DOSE_____FREQUENCY_____

ANY MEDICATIONS THAT WILL BE TAKEN WHILE STUDENT IS AT THE SCHOOL MUST BE CHECKED IN AT THE OFFICE IN ITS ORIGINAL PACKAGING INCLUDING OVER-THE-COUNTER MEDICATIONS WITH THE STUDENTS NAME PERMANTLY ATTACHED. Medications may only remain with a student with a written physicians request or for students 18 and older. Students are not permitted to share their medication of any kind with any other student.

LIST MEDICATIONS THAT CANNOT BE TAKEN_____

INSURANCE:

PRIMARY INSURANCE COMPANY _____
PHONE_____ GROUP#_____ID#_____
POLICY HOLDER'S NAME_____
RELATIONSHIP TO CHILD_____

SECONDARY INSURANCE COMPANY_____
PHONE_____ GROUP#_____ ID#_____
POLICY HOLDER'S NAME_____
RELATIONSHIP TO CHILD_____

STATEMENT OF CONSENT

In the event of an emergency or non-emergency situation requiring medical treatment, I hereby grant permission for any and all medical and/or dental attention to be administered to my child, in the event of an accidental injury or illness, until such time as I can be contacted. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel.

PARENT SIGNATURE:_____DATE:_____