Medical Release Form

Student's Name: ______________________________

Parent/Legal Guardian's Name: ______________________________

Address: ______________________________

Phone #s: Home: ________ ________ ____________

Work: ______________________________

Cell: ______________________________

Other: (______) ________ ____________

List all Known Medical Conditions, Including food allergies and/or drug allergies. .
Medical Conditions:
Allergies:

Please Note: **ANY** medications taken by your student on this trip must be accompanied by a doctor's note. This includes all over-the-counter medications.

In an Emergency, please contact: ______________ ____ _______

Relationship to child: ______________ ____ ______

Phone #s: ________ ________ ____________

________ ________ ____________ ________ ________ ____________

Or contact: ______________________ __

Relationship to child: ____________________ ____ _______

Phone #s: ________ ________ ____________

________ ________ ____________ ________ ________ ____________

,.

Physician's Name: ______________________________

Address:______________________________

Phone #s: __________ __________ __________ __________ __________ __________

Primary Insurance Company: ______________________________

Phone #s: __________ __________ __________ __________ __________ __________

Billing Address:______________________________

Policy Holder's Name:-__________________.,-________________

'Address:______________________________

Relationship to child:______________________________

ID #:.______________________________ Group/Policy:-__________'-__________

Statement of Consent: {To be signed in the presence of a legalized notary public;)

In the event of an emergency or nonemergency situation requiring medical treatment, I ______________________ hereby grant permission for any and all medical 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 administrat'ions·of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel.

Signature:______________________________.;,.______________. **Date:** __________

Notarization:

On this __________ day of ______________ __________'-' ______________________

personally appeared before me in______________________________County (in the state of__________

and, in my presence, signed this medical release form.

Name of Notary Official: ______________________________

Signature: ______________________________

Commission Expires: __________--'--______________________________

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Medication Authorization - (Temporary)

Student Name:___________________________--,-___________________Grade/Team:____________

Parent's Address:____Phone: _________

City: ________________________________State:_______________Zip Code: _____________________

Attending Physician: Phone:-________

Physician's Address:-____________________________________

____

To be completed byphysician:

Name of Medication:-______________________________

Dosage: ______________________ Frequency:....-- ______________

TimeofAdministration: ________________________________

Anticipated Duration: Start date:-_______________

Stop date:_________________________

Possible Side Effects:-________________ ____________

____

INHALERS:	*EPIPENS:*
Student may carry inhaler________	Student may carry epipen________
Student may NOT carry inhaler_________	Student may NOT carry epipen________

STUDENTS THAT CAR.RY INHALERS AND/OR EPIPENS MAY NOT BE 51:JPER'tl/SED DURING ADMINISTRATION

Physician's Signature:____ ________Date:___________________

I hereby request that my child be administered his/her prescribed medication by authorized personnel. I understand the medication will be administered exactly as per the instructions of my above named physician. I further agree that you may contact the physician who prescribed the medication and I hereby authorize him/her to release to the school officials any and all information concerning my child's condition and/or treatment.

Parent/Guardian Signature:· Date: ·

***Controlled substances such as Ritalin, Adderal1, Concerto, etc. must be picked up byparents ***

Medication MUST be in its' ORIGINAL container