

MEDICAL FORM

Student Name _____

Date of Birth _____

Home Address _____

Home Telephone Number _____

Other Telephone Numbers (in case of emergency) _____

Medical problems, allergies, or other factors which might influence medical treatment. (If none, please state NONE KNOWN.)

If the student is under a physician's care for ongoing medical treatment, please complete the following:

Condition: _____

List all medications the student is currently taking: _____

Physician Name and Telephone Number _____

If needed, student may take the following over the counter medication: (example- Tylenol, Advil etc.)
(List medications) _____

Student has the following dietary needs (ie: vegetarian): _____
We will do our best to accommodate a student's needs.

Name of Responsible Party _____

Employer of Responsible Party _____

Insurance Carrier _____

Group Number _____ Member Number _____

Medical Release Form

As parent or guardian of _____(name of student), I authorize treatment by a qualified physician or nurse in the event the student would require medical treatment. I understand that should a serious or life-threatening medical emergency arise, initial treatment of the student may be rendered by an individual trained in first aid, if in the opinion of that individual, delay might further endanger his or her health. In the Medical information portion of this form, I have listed any allergies, ongoing medical treatment or medical problems, which might influence treatment of the student. I will be responsible for charges incurred for the student's treatment. This permission is granted with the understanding that except in a serious medical emergency, a reasonable effort will be made to inform me before treatment.

Signature of Parent or Guardian: _____

Date: _____