

Academic Year: _____

Health Information & Medical Release Form

STUDENT NAME _____ BIRTH DATE ____ / ____ / ____

I, the undersigned, being the parent, legal next-of-kin, or legal guardian of _____, hereby authorize any necessary medical treatment for this person while participating in any South-Doyle High School Band functions during the proceeding academic school year. I also will be responsible for all financial responsibilities during medical treatment.

In regard to such person, I submit the following information:

1. Allergies to foods, medications. If none, write "none". _____

2. Special medical problems or health conditions. If none, write "none". _____

3. Medication(s) or prescription(s) to be used by student. If none, write "none".

Medication _____ Purpose _____

Medication _____ Purpose _____

Medication _____ Purpose _____

4. In the event that we cannot reach you, do we have permission to give any of the following medicines to your child?
(Please mark yes or no for each line)

Benadryl Yes _____ No _____
Pepto Bismol Yes _____ No _____
Advil/Ibuprofen Yes _____ No _____
Antacids (Mylanta, etc.) Yes _____ No _____

Tylenol Yes _____ No _____
Kapectate/Imodium Yes _____ No _____
Sudafed Yes _____ No _____
Dramamine Yes _____ No _____

5. My child is prescribed and carries an Epipen Yes _____ No _____ an inhaler Yes _____ No _____

6. Date of last Tetanus shot? _____

7. Family Physician _____ Phone _____

8. Person(s) other than parent or guardian to notify in case of emergency:

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

9. Health Insurance Carrier _____ Policy Group # _____

Policy Holder's Name _____ ID # _____

I hereby give permission and approval for any and all medical and surgical treatments, including anesthesia and operations which may be necessary and or available to my son or daughter by the attending physician and surgeons. The intention hereof is to grant authority to administer and perform all and singularly, any procedure that may now or during the course of the patient's care be deemed advisable or necessary. I/we also agree that the patient, when admitted, is to remain in the hospital until his/her physician recommends the patient's discharge. Every effort will be made to contact the parent(s) or guardian(s) in advance of treatment, by telephone, in case of injury or illness.

Parent/Guardian Signature _____ Date _____

Notary Public _____ Date _____ Expire _____