STUDENT MEDICAL CONSENT

Please complete this **Medical Information Consent.** *Return it to the Director or Teacher in Charge.*
It is important this form be notarized in the event of medical emergencies and your parent/guardian(s) aren't immediately available.

Student Last Name _____ First _____
Parent/Guardian _____ Address: _____ City_____ ST _____ZIP_____
Daytime Phone (home or work) _____-_____-_____ Evening Phone (home or cell) _____-_____-_____
Parent/Guardian (if different) _____Address: _____ City _____ ST _____ ZIP _____
Daytime Phone (home or work) _____-_____-_____ Evening Phone (home or cell) _____-_____- _____
In Case of Emergency call: _____ at #_____-_____-_____
Does Student have insurance? Yes _____ No _____ Insurance Company Name _____
Name Insured under _____ Policy Number _____ Group # _____
Physician Name _____ Physician Phone Number_____-_____-_____

Student Health History (check or list)
_____ Diabetes
_____ ADD/ADHD
_____ Asthma
_____ Epilepsy
_____ Cardiac Problems
_____ Eating disorders/conditions
_____ Orthopedic Problems_____
_____ Other (explain) _____

Allergies: (check or list)
_____ Aspirin
_____ Penicillin
_____ Sulfa
_____ Insect Bites
_____ Tetracycline
_____ Acetaminophen
_____ Foods _____
_____ other (explain) _____

List any medications your child is currently taking, the purpose and dosage/frequency:
_____
_____

Explain any allergies or allergic reactions your child may have (food, medications, etc.) and treatment generally given:
_____

Do we have permission to administer to your child? (Check those allowed).
_____ Aspirin (Bayer) _____ Ibuprofen(Advil/Motrin) _____Acetaminophen (Tylenol) _____ Dramamine

Has your child had a tetanus shot within the last 6 years? _____ No _____Yes Date: _____

Do you know of health factors that make it advisable for your child to follow a limited program of physical activity or from participating in any activities?

_____No _____Yes Explain: _____

Does your child require special needs be arranged (hotel room, theater seating, steps vs elevators, diet)? _____ No _____Yes
Explain: _____

MEDICAL CONSENT:
I give my permission to administer prescription or non-prescription medications listed on the form above. I will provide all Medications in **original** containers. Photocopies of prescriptions are required so they can be easily replaced if lost.
I give my permission to the physician, hospital or emergency team to secure proper treatment & to order medications, injections, anesthesia or surgery for my child named above. I understand the staff, chaperones or director will make every attempt to contact myself or other emergency contacts listed above regarding my child's condition.

Student Signature _____ Date _____

Parent/Guardian Signature_____ Relationship to student _____Date _____

Signed before me this _____ day of _____, 20__

_____
Notary Public

My commission expires _____

Stamp: