

HEALTH FORM - MEDICAL RELEASE

STUDENT NAME: _____

M () F ()

DATE OF BIRTH: _____

AGE: _____

HEALTH HISTORY

(Major hospitalizations, surgeries, injuries (include the year))

SPECIAL CONDITIONS

(Please list any medical conditions or other physical or mental conditions we should know about including eating disorders)

(List the usual treatments for condition(s) above)

ALLERGIES

(List allergy and treatment – include foods)

MEDICATIONS

(List ALL medications the student will have with him/her)

Medication	Dose	Frequency	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

IMMUNIZATION DATES

MMR _____ DP Tetanus Booster _____ Hepatitis B _____ Other _____

DOES THIS STUDENT USE AN INHALER? Yes () No ()

HAS THIS STUDENT BEEN EXPOSED TO ANY INFECTIOUS CONDITIONS IN THE LAST TWO WEEKS? Yes () No ()

If yes, please explain:

INSURANCE INFORMATION

Attach clear copies of BOTH sides of your health insurance card OR fill in the information below that applies to your insurance carrier/coverage.

Name Policy is in: _____ Policy holder's date-of-birth _____

Identification Number(s) _____

Insurance company name _____

If Blue Cross/Blue Shield, list state _____ Group Number _____

Contract number _____ Service Code _____

Address to send claim _____

Employer name _____

Medicare _____ Medicaid _____

I hereby grant permission to the medical personnel selected by the director to order x-rays, routine tests, and treatment of my child, and in the event I cannot be reached in an emergency, I hereby give permission to the physician selected by the director to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child as named above. I also grant permission for medical personnel to obtain access to necessary medical, psychiatric or social work records. I hereby personally assume full responsibility for any and all Claims and for any and all hospital and medical bills for my student. I will maintain in full force adequate primary medical insurance for my student. This form may be photocopied.

Parent/Guardian Signature _____ **Social Security No.** _____ **Date** _____

Address _____ **City, State, Zip** _____

Emergency Phone Number _____ **Cell Number** _____