

Grade: 8 9 10 11 12 Student Name: _____

Male Female

Age: _____

Date of Birth: _____

Health Information and Medical Services Authorization

Name(s) of parent/guardian with whom student resides _____

Home Address _____

Father _____ Home Phone _____ Cell Phone _____

Mother _____ Home Phone _____ Cell Phone _____

Current medical conditions, mental health diagnosis, and recent surgeries:

Allergies (Please list all and describe reaction):

Does your student require an Epi-pen, rescue inhaler, or emergency medication during this event?
(Requires physician order and written parental consent) Yes No

Current Medications Name of medication, dosage, and condition being treated:

*Any and all medications MUST BE delivered in the original package. *Any and all medications to be given during the event require a written order from the student's physician and parental permission. *Any and all medications must be delivered directly to the health office immediately upon entering the event.

Did your student receive any recent Immunizations? Yes No If yes, name of immunization and date given: _____

Please list other persons we may call for advice or direction in caring for your student in the event we are unable to contact a parent or guardian.

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

In case of emergency, if the parents (or guardians) cannot be contacted immediately, I give my permission to have the student taken to Elk Regional Health Center and I will assume any expenses. I also give my permission to make information on this form available to authorized event and transportation personnel.

Parent / Guardian Signature

Date:

Insurance Provider and Policy Number

Permission to Give Medication

Please initial after each individual medication that you authorize event personnel to administer to your student. Medications without an initial cannot be administered.

Acetaminophen _____
(Tylenol or non-asprin substitute)

Ibuprofen _____
(Maximum 400mg, weight based dosing)

Throat Lozenge / Cough Drop _____
(Sore throat, cough)

Tums _____
(Stomach complaints)

Ora-Jel / Anbesol _____
(Mouth / tooth problems)

Neosporin / Bactine Spray _____
(Minor Wounds)

Contact Lens Solution / Eye Wash _____
(Eye complaints)

Caldyphen Klear Lotion _____
(Topical analgesic for skin irritation)

I certify that this information is current and accurate to the best of my knowledge:

Signature: _____ Date: _____