

**Student Medical Release**  
(for student participants, under 18 yrs of age)

Name of Student: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone #: \_\_\_\_\_

**Emergency Medical Treatment:** In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical attention. I wish to be advised prior to any further treatment by the doctor and hospital. If you are unable to reach me, contact:

Emergency contact \_\_\_\_\_ Phone # \_\_\_\_\_

Relation to participant \_\_\_\_\_

**If you are unable to reach parent/guardian or the emergency contact person, I hereby grant permission for the doctor and hospital to exercise professional judgment in treating participant.**

Medical / Hospital Insurance Carrier \_\_\_\_\_

Name of Policy Holder \_\_\_\_\_ Relation to participant \_\_\_\_\_

Policy Number \_\_\_\_\_ Group Number \_\_\_\_\_

Signature of Parent / Guardian \_\_\_\_\_ Date \_\_\_\_\_

Father/Guardian's full name: \_\_\_\_\_

Home address: \_\_\_\_\_

Home Phone #: \_\_\_\_\_ Work or Cell Phone #: \_\_\_\_\_

**Both pages must be signed by Parent/Guardian**  
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**Mother/Guardian's full name:** \_\_\_\_\_

**Home address:** \_\_\_\_\_

**Home Phone #:** \_\_\_\_\_ **Work or Cell Phone #:** \_\_\_\_\_

Medications: My child is taking the following medication(s):

Description \_\_\_\_\_ Dosage \_\_\_\_\_

Description \_\_\_\_\_ Dosage \_\_\_\_\_

(EITHER A PHYSICIAN'S PRESCRIPTION OR PARENT NOTE MUST ACCOMPANY ALL MEDICATIONS. PRESCRIPTION / NOTE SHOULD BE ATTACHED TO THIS FORM.)

I hereby grant permission for non-prescription medications to be given, if deemed appropriate.

\_\_\_\_\_ Yes    \_\_\_\_\_ No

Drug allergies

\_\_\_\_\_

Other allergies / reactions (food, plants, insects, etc.)

\_\_\_\_\_

List any other health problems / limitations that we need to be aware of

\_\_\_\_\_

Signature of Parent / Guardian \_\_\_\_\_ Date \_\_\_\_\_

**Both pages must be signed by Parent/Guardian**

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