MEDICAL RELEASE FORM

Student's Name_____ D.O.B.: _____ ____

Address_____ Phone (___)_____

_____

Parents'/Guardians' Names_____

Address *(if different from child's)*_____

Insurance Company_____ Policy #_____

1. Is your child allergic to:

___ bee sting____ pollens___ other drugs _____ ___ hay, straw
____ penicillin other _____

2. Does your child have any life-threatening allergies? ___ Yes ___ No *(If yes, to what?)*

_____

_____

3. Is your child bringing any medication with him/her? ___ Yes ___ No
If yes please list and state dosage:

_____

_____

PLEASE NOTE: Medication should be in its original prescription bottle/package, which should have administration instructions and the child's name clearly indicated.

4. Does your child have any physical, emotional, mental, or behavioral concerns or limitations that our staff should be aware of? ____ Yes ___ No *(If yes, please explain)*

_____

_____

5. Has your child ever had:___ seizures___ asthma___ diabetes
___ homesickness___ heart disease___ other _____

6. Date of last tetanus shot: _____