



MEDICAL HISTORY RELEASE FORM

Student's Name _____ Birth Date ____/____/____ Grade to Enter _____
Last First

Address _____ Male Female
Street City State Zip

Mother/Guardian:

Name _____ Home Phone _____ Cell Phone _____
 Address _____ City _____ Zip _____
 Employer _____ Work Phone _____ Pager _____
 Email _____ Church affiliation _____

Father/Guardian:

Name _____ Home Phone _____ Cell Phone _____
 Address _____ City _____ Zip _____
 Employer _____ Work Phone _____ Pager _____
 Email _____ Church affiliation _____

MEDICAL INFORMATION REGARDING STUDENT

Has the student had any difficulty with the following:

Hearing	yes <input type="checkbox"/> no <input type="checkbox"/>	Eyesight	yes <input type="checkbox"/> no <input type="checkbox"/>	Heart problems	yes <input type="checkbox"/> no <input type="checkbox"/>
Frequent colds	yes <input type="checkbox"/> no <input type="checkbox"/>	Diabetes	yes <input type="checkbox"/> no <input type="checkbox"/>	Hernia	yes <input type="checkbox"/> no <input type="checkbox"/>
Asthma/Hay Fever	yes <input type="checkbox"/> no <input type="checkbox"/>	Pneumonia	yes <input type="checkbox"/> no <input type="checkbox"/>	Back problems	yes <input type="checkbox"/> no <input type="checkbox"/>
Allergies	yes <input type="checkbox"/> no <input type="checkbox"/>	Headaches	yes <input type="checkbox"/> no <input type="checkbox"/>	Knee problems	yes <input type="checkbox"/> no <input type="checkbox"/>

Allergic to: _____ Type: _____ Date of last tetanus shot? ____/____

Is the student currently taking any medications? yes no If yes, explain: _____

Any medications brought to school? yes no If yes, what is the name of the medication? _____

Note: All medications brought to school or camp need to be turned into the office.

Has the student had any injury or physical condition that should be watched? yes no

If yes, explain including any operations or serious accidents: _____

Is there any reason why the student should not take physical education? yes no

If yes, provide a note from your physician directly to the school.

May your child be given: Tylenol Jr. yes no Tylenol Reg. Strength yes no

IN THE EVENT YOUR CHILD BECOMES ILL OR HAS AN ACCIDENT AT SCHOOL, AT CAMP OR ON A FIELD TRIP, PROVIDE THE CONTACT PHYSICIAN'S NAME:

Name _____
Physician's name Phone # Hospital

Address _____
Street City State Zip

Do you have accident/medical insurance? yes no

Supply provider's coverage information below:

Coverage Provider Group # Policy # Expiration date

Provide the names of a friend, neighbor or relative (Other than a parent), who can be contacted by phone in the event we are unable to contact a parent in the event of an emergency:

Name _____ Relationship _____ Phone(____) _____

Name _____ Relationship _____ Phone(____) _____

Name _____ Relationship _____ Phone(____) _____

Name _____ Relationship _____ Phone(____) _____

Please read over carefully

I/We hereby give my permission for my child to take part in all activities, including sports, school sponsored field trips, and camps away from the school premises. I absolve the school from all liability because of accident or injury to my child at school or during school activities. In case of accident or serious illness, the school agrees to contact the parent(s). If the school is unable to reach the parent(s), this will act as authorization for the school to call the physician listed on this medical form and to follow his/her instructions. If it is impossible to contact this physician, the school may make whatever arrangements deemed necessary for emergency medical treatment.

In consideration of the right to participate in the activities arranged for the above mentioned student by Golden Hills Christian School, I have and hereby assume for my student all risks and hold the school, and all persons associated with the above entities in any way harmless from any and all liability, action, cause of action, consent for medical treatment of any kind, debts, claims, demands of every kind and nature whatsoever which may arise from of in connection with his/her participation in the arranged activity. The terms shall serve as a release and assumption from all risk and liability, known or unknown, or anticipated arising from the giving of any consent here under for my student.

Reasonable efforts, time permitting, will be made to reach parents prior to consent to any medical treatment.

In case the student is injured or requires medical treatment you are authorized to have him/her treated.

Father's/Guardian's Signature

Date

Mother's/Guardian's Signature

Date