SOUTHERN LYON COUNTY U S D #252

PARENTS MUST COMPLETE ENTIRE FORM IN FULL FOR EACH STUDENT

Medical Release Form

Student Name: _____

Family Medical Information				
	Name	**Contact #**	**Insurance Company**	**Policy #**
Hospital Preference				
Health Care Provider				
Dentist				
Optometrist				

Medical Information		
***When was this student's last tetanus shot?		**Date**
X	**Please Mark Any That Applies to Student**	**Please Explain**
	Difficulty Breathing After Exercise	
	Asthma (List Inhaler medication below)	
	Migraines	
	Heart Condition	
	Concussion/Head Injury	
	Seizures	
	Menstruation (If problems please explain)	
	Surgeries or Serious Injuries in the Past	
	Wears Glasses/Contacts	
	Wears Hearing Device	
	Other:	

Medications	
Please list all medications that Student takes on a regular basis (include over the counter meds.(e.g. Tylenol, vitamins, supplements, etc.)	
Name of Medication	**Reason for Medication**

Allergies		
Allergy Category	**Specify Allergy**	**Carries Epi Pen**
Foods		
Insects		
Medications		
Environment		

I, _____, the parent or legal guardian of _____, give my consent for my child to participate in **any school sponsored activity**. I further give my legal consent and authorize any representative of Southern Lyon County USD 252 to authorize emergency medical treatment, including any necessary surgery or hospitalization, for my above named child, for any injury or illness of an emergency nature he/she incurred while participating in the activity noted above by any physician or dentist licensed in accordance with the provisions of the Kansas Healing Arts act, K.S.A. 65-2801 and any hospital. I agree to pay and assume all responsibility for medical and hospital expenses and any emergency service incurred on behalf of my child. I acknowledge and agree that Southern Lyon County USD 252 is not responsible for any medical, hospital expenses and/or charges that are incurred in the medical treatment or hospitalization of my child. A photo copy of this document shall have the same force and effect as the original. If my child requires emergency medical treatment, I understand that school personnel will make a reasonable attempt to contact me to seek my permission to authorize treatment. To facilitate contacting me, I agree to provide current work and home phone numbers to the school.

Parent/Guardian Signature_____ Date_____