**MEDICAL & INFORMATION RELEASE FORM**

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| **Student Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_  Last First Middle Initial  **Mailing Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_  House number Street Apt. No.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  City State Zip Code  **Date of Birth:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Home number**: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Work/Cell:** **** Mother  Father  Guardian( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **Name of Doctor:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Telephone Number:** ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Address:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_  Street City State Zip  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Insurance Company Name Policy Number:** |

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| **Please note that in case of an emergency, we will always contact parents / guardians first.**  **The information below will only be used if parents / guardians cannot be reached.**  **Please provide information of someone other than a parent / guardian.**  **In case of accident, notify**:  Mr.  Mrs.  Ms. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Telephone Number**: Home: ( ) Cell: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Relationship to the student:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

\*\*\* turn form over\*\*\*

**1.** **Check all that apply.** **I give permission for my student to be given:**

**** Aspirin **** Tylenol **** Advil

**2**. **Does your student have any limitations to physical activity?** **** No **** Yes - If YES, please explain.

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**3**. **Is your student on any medications? ** No **** Yes - If YES, please list below.

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**4**. **Does your student have any allergies, including food allergies**? **** No **** Yes - If YES, please list below.

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**5**. **Does your student have any special needs for accommodations or is there any other medical concerns that we should be aware of?** **** No **** Yes - If YES, please list below.

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* I authorize the teacher, program leader or qualified medical personnel to take whatever first-aid action is deemed necessary, in their sole judgment, to protect my student’s health and safety in the event of any emergency. I agree that the program will not be responsible for or liable for any act, error, omission, or for any personal injury.
* I hereby give consent to allow my student to receive medical treatment which may be deemed advisable in the event of injury, accident, and/or illness during this program. Permission is hereby granted for any emergency medical treatment, operation, anesthesia, or inoculation that might be needed.
* In addition, I hereby give my permission as parent/legal guardian for my student to participate in trips, athletic activities, and the Wide Angle Vision program (i.e. hiking, canoeing, technical rock climbing, high ropes course & caving) until he/she officially withdraws or terminates himself/herself from the program.

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**Signature:**  Mother  Father  Guardian **Date**