ANNUAL MEDICAL RELEASE FORM

Student Name _____School_____

Birthdate_____ Grade ____ Teacher/Advisory_____

Home Address _____

Name of Parent or Guardian _____

Daytime Telephone Number _____

Alternate Person for Emergency Call _____

Alternate Person's Daytime Phone Number _____

MEDICAL HISTORY

Medical problems we should know about? Asthma, allergies, seizures, heart, diabetes, eyes, ears, etc

Explain _____

_____

Should any drug (penicillin, sulfa, etc.) be avoided? Yes No _____

Are there any allergies (Food, Latex, bee stings, etc.)? Yes No Student has an Epi-Pen Yes No

Medications child takes every day at home? _____

Medications child takes every day at school? _____

Any student that needs prescription medications at school must follow the district policy which requires parent and physician signature. Forms are available in the health office or at www.isd518.net. **Signed forms are required before medication can be administered.**

Medications child takes as needed (Inhaler, Neb, etc.)? _____

Are immunizations up to date? Yes No (Please verify with School Health office)

Name of Family Doctor/Clinic_____

Doctor's Office Phone Number _____

Medical Insurance Company Name and Policy Number No insurance_____

_____

Health information will be kept confidential and may be shared with school staff and bus drivers. I hereby give permission to the staff of Independent School District 518, Worthington, MN to give and receive immunization information with my child's doctor, medical clinic, or public health and to seek immediate medical attention for the child named above. I hereby give permission to the physician to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child, as named above. I will assume all insurance and medical expenses for my child.

_____ _____

(Date) (Signature of Parent or Guardian) 3/15wd