ANNUAL MEDICAL RELEASE FORM
School Year 2019-2020

Student Name _____

Birthdate_____ Grade ____ Teacher/Advisory _____

Home Address _____

Name of Parent or Guardian _____

Daytime Phone Number(s) _____

Emergency Contact_____

Emergency Contact Daytime Phone Number_____

MEDICAL HISTORY

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

Explain _____

_____

Any severe allergies? (Food, Latex, bee stings, etc.) Yes No Student has Epi-Pen Yes No

Medications child takes every day at HOME? _____

Medications student 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 only when needed (Inhaler, Neb,etc.)? _____

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

Name of Family Doctor/Clinic_____

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) 2/19jb

Office Use Only

☐ **IHP**

☐ **ECP**

☐ **504**