

EMERGENCY MEDICAL RELEASE FORM

STUDENT'S NAME _____

Student's: Home Address _____

Student's: Home Phone _____ Date of Birth _____

Physician's Name _____ Phone _____

Physician's Office Address _____

Mother's Name _____ Work # _____

Cell # _____

Father's Name _____ Work # _____

Cell # _____

STUDENT HEALTH INSURANCE INFORMATION:

Company Name: _____ Policy Holder's Name: _____

Policy # _____ Policy holder S.S.# _____

PLEASE ATTACH A COPY OF YOUR MEDICAL INSURANCE CARD (HOSPITALS REQUIRE THIS INFORMATION BEFORE TREATMENT!!!)

Date of Last Tetanus Shot _____

Special Medical Problems: Is Student now under medical care (attach additional information if needed)? _____

List any allergies: _____

Does student carry medication on person? Please circle: YES NO

Medication _____ Purpose _____

Medication _____ Purpose _____

In your absence would you allow another parent to give your child:

Tylenol ___ Advil ___ Sudafed ___ Benadryl ___ Neosporin ointment ___ Antacid _____

(Please specify yes or no)

In case of an emergency, IF I CANNOT BE REACHED, I hereby give the Band Director of Fuquay-Varina High School, or an Adult Chaperone, consent to approve emergency medical treatment, understanding that I will be contacted as soon as possible.

SIGNATURE OF PARENT OR LEGAL GUARDIAN:

(X) _____ Date _____