MPSMA—MEDICAL RELEASE/INFORMATION FORM **TODAY'S DATE:**______________________________

PLEASE USE BLACK OR BLUE INK ONLY. If More Room Is Needed For Any Section, Please Use Back of This Form

Please PRINT Participant's
FULL LEGAL Name: ____ **Date of Birth:**____________________________

Street Address: ____

City:____ **State:**_____________ **Zip Code**_________________________

Emergency Contact #1____
Name | Relationship | Phone (please designate if cell, work or home)

Emergency Contact #2____
Name | Relationship | Phone (please designate if cell, work or home)

Pertinent Past Medical History (including past hospitalizations & surgeries). (Use reverse side if needed).:
____
____
____
____

Currently under the care of a physician for:
____

I give my permission for my son/daughter to take or be given the following over the counter medication (OTC): (Please circle all that apply)

Tylenol Advil/Motrin Pepto Bismol Imodium A-D Benadryl Cough Drops Tums

Other over the counter medication and/or Herbal Medication: Please List:____

Food & Drug Allergies (if more space is needed, please use reverse side):

Allergy	Reaction To The Allergen
________________________________	________________________________
________________________________	________________________________

Medications my son/daughter is currently taking. Include all over the counter & Prescription medication taken regularly (use reverse side if needed).
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☐ **My child has my permission to carry their own Inhalers or Epi-Pen (please check if you approve)**

PRIMARY INSURANCE: Policy #: _______________ **Group #:**________________________ **ID#:** _______________

Name & Address of Insurance Company: ____

Phone # :__________________________________**Policy Holder (Employer):**____________________________________

Employee's Name:___________________________ **Relationship to student:** ____________________________________

If you would like to add a secondary insurer and/or dental insurer, please put information on the back and include copies of the insurance cards.

In the event of an emergency or non-emergency requiring medical treatment, I ____, hereby grant

permission for any and all medical and/or dental attention to be administered to my child,_______________________________ in the event of an accidental injury or illness, until such time as I can be contacted. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel.

Parent/Guardian's Name (SIGNATURE): ____ Date: ____________________

Parent/Guardian's Name (PRINT): ____

Phone numbers: Cell______________________________; Home;______________________________; Work: ___________________________