MEDICAL PERMISSION FORM

(Please print or type)

Name:_____ Date of Birth:___/___/___ Home Phone: (___)_____
Last First MI

Address:_____ Sex:___ SSN:___-___-____
Number & Street City State ZIP

EMERGENCY INFORMATION

Parents' Name(s):_____ Work Phone:(___)_____ or (___)_____

Emergency Contact (if parents cannot be reached):_____ Phone Number: (___)_____

Physician's Name:_____ Phone Number: (___)_____

Who is responsible for medical payments? ☐ Insurance ☐ Individual

IF INSURED, Medical Insurance Company Name:_____ Phone Number: (___)_____

Address:_____
Number & Street City State ZIP

Name of Insured:_____ SSN of Insured:___-___-____

NOTE: Please attach a copy of the insurance card and driver's license of the primary insured person.

BRIEF MEDICAL HISTORY

Special Health Concerns (allergies, etc.):_____

_____

Allergic to any medications? ☐ Yes ☐ No If yes, please list:_____

Current Medications:_____ Dosage per day:_____

NOTE: If you are taking medication regularly, please bring a supply in a labeled container.

Asthma: ☐ yes ☐ no Medication:_____
Diabetes: ☐ yes ☐ no Medication:_____
Epilepsy: ☐ yes ☐ no Medication:_____
Heart: ☐ yes ☐ no Medication:_____

Should activity be restricted? ☐ yes ☐ no If yes, please explain:_____

Are there any prescription or non-prescription drugs that should NOT be administered?_____

The trip advisor(s) may provide my child with: ☐ Tylenol ☐ Advil ☐ Either ☐ Neither

I, the parent or legal guardian of _____ (my child), authorize and direct the Clark County School District to obtain medical care for my child in the event such care is reasonably necessary. I understand that, if possible, I will be contacted in the event my child requires medical attention. I grant to a licensed health care provider or accredited hospital permission to perform any reasonably necessary medical and/or surgical procedures that are essential for the treatment of my child and agree to be responsible for payment for such care. I release CCSD, its employees, and agents from any damages, liability, or loss resulting from the exercise of discretion in securing in good faith medical care for my child.

Parent or Guardian Signature:_____ Date:_____

DISTRIBUTION OF APPROVED COPIES: WHITE-Advisor, YELLOW-Activities Administrator