Medical History Permission and Release Form

The following health history and permission for medical consent is requested in the event that medical treatment will need to be sought for your child when you cannot be contacted. ALL INFORMATION IS CONFIDENTIAL. Only those persons attending to your child's medical needs will be allowed to view this data.

Student's Name _____ Age ____ Date of Birth _____ SS#_____

Home Address _____ Zip _____

Parent/Guardian Work Phone _____ Cell _____ Hm _____

In case of emergency, notify: _____ relation: _____Phone: _____

Family Physician _____ Phone _____

Family Insurance Co: _____Policy # : _____ Group #_____

Insurance Co. Address: _____

IMMUNIZATIONS ☐ Tetanus ☐ Polio Booster ☐ Measles ☐ Mumps __Other: _____

PAST MEDICAL HISTORY :

o Asthma	o Heart	o Hay Fever
o Sinusitis	o Diabetes	o Pacemaker
o Bronchitis	o Dizziness	o Head Injury
o Kidney	o Stomach Upset	o Other _____

ALLERGIES:

o Food_____	o Penicillin	o Poison Sumac, Oak, or Ivy
o Peanut	o Other drug :	o Insect bites/stings
o Diary	_____	o other _____

Previous Operations or serious illness:_____

SPECIAL AWARENESS:

Current medications: _____

Special Diet (name) _____ VEGETARIAN _____

Childhood Diseases: ___Chickenpox ___Measles ___Mumps ___Whooping Cough

Any medical needs that your child has, of which adult supervisors should be aware:

_____

PERMISSION FOR TREATMENT: My permission is granted for school supervisors to obtain necessary medical attention in case of sickness or injury of my student. I release and waive, and further agree to indemnify, hold harmless or reimburse the Celina Independent School District, the Board of Education, its successors and assigns, its members, agents, employees. and representative thereof, as well as trip supervisors, from and against, any claim which any other parent or guardian, any sibling, the student, or any other person, firm or corporation may have or claim to have, known or unknown, directly or indirectly, from any losses, damages or injuries arising out of, during or in connection with the student's participation in the trip or the rendering of emergency medical procedures or treatment, if any.

DATED this _____of _____,20___

_____ _____

Signature of Parent/Guardian Notary [REQUIRED]