

Holy Spirit Episcopal School
Medical Release & Medical Information Form
DUE BY AUGUST 2, 2010

Student Name: _____ (Circle one) Male Female Grade/Class: _____

Address: _____
 Street Number Street Name Apt. # City Zip

Birth Date: _____ Age: _____

Lives With: Name Relationship Home Phone Work Phone Cellular Phone

Mother/Guardian: _____

Father/Guardian: _____

The individuals listed below may be contacted if the above named student becomes ill and the parent or guardian cannot be reached, and they also have permission to pick the student up from school.

Other Contact Names: Relationship Home Phone Work Phone Cellular Phone

Emergency Medical Care Authorization:

In accordance with the provisions of Chapter 35 of the Texas Family Code, I _____, the undersigned parent or guardian of minor child, do hereby authorize Holy Spirit Episcopal School (herein referred to as the "School") to administer first aid treatment and/or obtain necessary emergency medical care for my child from a licensed medical professional or from a hospital or medical facility as a result of any medical emergency which arises while my child is in the custody of the School. I hereby give my consent to any X-ray examination, anesthetic, medical, or surgical treatment which arises while my child is in the custody of the School. I understand the cost of such care will be paid by me. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power on the part of the School to give specific consent to any and all such necessary emergency medical care for my child which the said physician/surgeon in the exercise of his best judgment may deem necessary. I understand that a conscientious effort will be made to contact me or the person(s) I have designated above in the event of an emergency if we can be reached and if time permits.

Parent Signature: _____ Printed Name: _____ Date: _____

Medical Information:

Height: _____ Weight: _____ Primary Doctor: _____ Primary Doctor Phone #: _____

Insurance Company: _____ Policy # _____ Group Policy Company Name: _____

Current Medications: _____ Dosage: _____

Allergies: _____ Reactions: _____

Date of most recent tetanus immunization: _____

Mark if any of the following applies to the student:

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Emotional Disorders |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Migraines/ Headaches | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Chronic Illnesses or Disease |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Glasses/Contacts | <input type="checkbox"/> Physical Disabilities/Limitations | <input type="checkbox"/> Bowel/Intestinal Issues |
| <input type="checkbox"/> Asthma/Respiratory | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Subject to High Fevers | <input type="checkbox"/> Skeletal Problems |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Earaches/Ear Tubes | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Urinary, Kidney, or Bladder |

If you marked any of the above please explain: _____

Any accidents or illnesses? _____ Under a doctor's care and why? _____

Anything else that we need to know? _____

Vision and Hearing screening for <u>new</u> students, 4 year olds, kindergarten, first, third, fifth, and seventh graders:			
Vision Acuity Screening	20/ _____	Hearing Screening	_____
	R	L	Examiner
	R	L	Date
6th, 7th, 8th Grade Spinal Screening: Normal: _____ Referral: _____			

This child has been examined by me and is physically and mentally able to participate in group activities.

Physician: _____ Physician's Signature: _____ Date: _____
 Printed Name