

Hillgrove Bands Medical History Permission and Release Form

Full Name _____ Age _____

Address _____ Zip _____

If unable to reach parents in case of emergency notify _____

Relationship _____ Phone _____ Alternative Phone _____

Family Physician _____ Phone _____

Family Insurance Co _____ Policy # _____

Insurance Co. Address _____

Student's Social Security # _____ (Provide a copy of insurance card)

IMMUNIZATIONS CURRENT: Yes: _____ No: _____ Date of last Tetanus shot: _____

Other: _____

PAST MEDICAL HISTORY

Asthma _____ Sinusitis _____ Bronchitis _____ Kidney _____ Heart _____ Diabetes _____
Dizziness _____ Stomach Upset _____ Hay Fever _____ Other _____
Seizure Disorder _____ Please provide details on back for all Yes or checked items.

My student *may* be administered the following over the counter medications unless marked **NO**
Hydrocortisone cream _____ Topical Bee sting relief _____ Antibiotic Cream _____ Tums/antacid _____
Pepto-Bismol _____ Acetaminophen _____ Ibuprofen _____ Solarcaine _____ Benadryl _____
Aspirin _____ Tylenol _____ Advil _____

ALLERGIES: Food _____ Insect bites/stings _____

Medication (name) _____

Poison Sumac, Oak, or Ivy _____ Inhaler(s) or Epi Pen needed? _____

Other _____

Previous Operations or serious illness _____

Daily medications including: RX, OTCs, Herbal, natural _____ (list on back if necessary)

Special Diet (name) _____

Childhood Diseases: Chickenpox Measles Mumps Whooping Cough

Any medical needs, which your student has, of which adult supervisors should be aware: If more space is needed for medical information or treatment plans, please write on back.

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 Cobb County 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 I, 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 _____

Student Name: _____	DOB _____	Home# _____
Father's Name: _____	Work # _____	Cell# _____
Mother's Name: _____	Work # _____	Cell# _____
Emergency Contact: _____	Work # _____	Cell# _____