



Today's Date: \_\_\_\_\_ For School Year: \_\_\_\_\_

I hereby give my consent to any hospital and/or licensed doctor to administer the necessary emergency treatment to my child in the event such treatment is imperative and I cannot be contacted.

Student Legal Name	Social Security #	Date of Birth	Grade	Sex
				M <input type="checkbox"/> F <input type="checkbox"/>

Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home Phone # \_\_\_\_\_

Legal Guardian	Home Phone #	Cell/Beeper #
Mother's Name _____ Yes <input type="checkbox"/> No <input type="checkbox"/>		
Father's Name _____ Yes <input type="checkbox"/> No <input type="checkbox"/>		

Step Parent's Name (if applicable) \_\_\_\_\_

Name of Person, Address and Relation <small>who will assume responsibility if parent cannot be reached</small>	Home Phone #	Work Phone #	Cell/Beeper #

Names of brothers and sisters who attend KCS: \_\_\_\_\_

Physician's Name	Phone #	Dentist's Name	Phone #

Hospital Preference \_\_\_\_\_ Phone # \_\_\_\_\_

Name of Medical Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

In case of an accident or serious illness, the school will contact the parent/guardian. If the school is unable to contact the parent/guardian or person designated above, the school will contact the physician or will make necessary arrangements for immediate treatment. Payment of the fees will be assumed by the parent/guardian.

List Allergies	Date Diagnosed	Medication	Symptoms

If your physician has ordered an EPIPEN, where is it kept while at:

School \_\_\_\_\_ Sports \_\_\_\_\_ Band \_\_\_\_\_ Field Trips \_\_\_\_\_

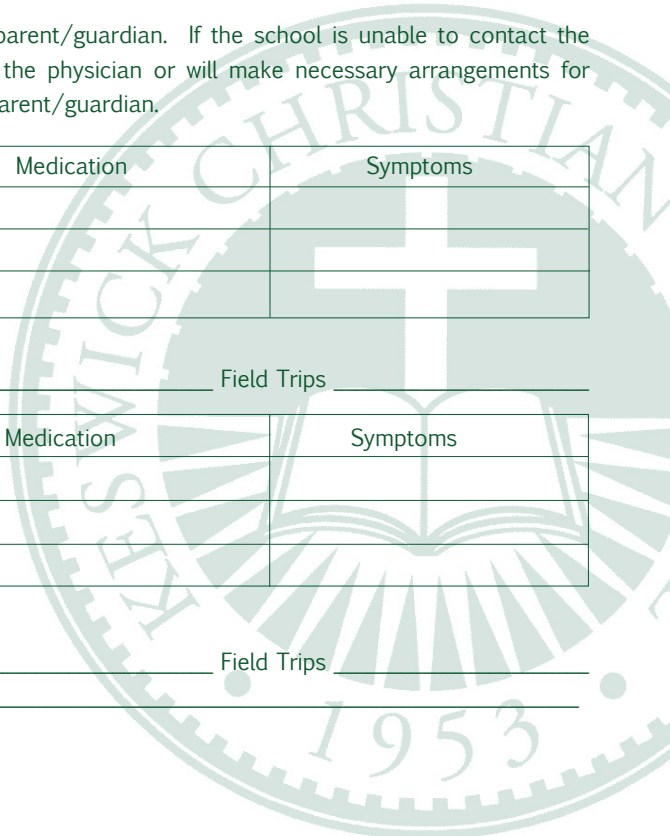
Asthma	Date Diagnosed	Medication	Symptoms

If your child uses an inhaler for asthma, where is it kept while at:

School \_\_\_\_\_ Sports \_\_\_\_\_ Band \_\_\_\_\_ Field Trips \_\_\_\_\_

Is asthma worsened with exercise? Yes  No  Explain \_\_\_\_\_

MEDICAL RELEASE K-12





MEDICAL RELEASE K-12

Illness	Date Diagnosed	Medication	Symptoms Your Child Experiences
Bowel Disorders			
Cancer			
Convulsions/Seizures			
Diabetes Mellitus			
Hearing Problems			
Hyperactivity			
Kidney Disorders			
Lung Disorders			
Migraines			
Orthopedic Disorders			
Dental Problems			
Other			

Wears glasses? Yes  No  Wears contacts? Yes  No

Does the student use any monitoring devices or medical equipment while at school? Yes  No

If so, please explain \_\_\_\_\_

Does the student have a chronic health problem? Yes  No

If so, please explain \_\_\_\_\_

Has your child ever had surgery? Type: \_\_\_\_\_ Date: \_\_\_\_\_

State any disabilities or restrictions: \_\_\_\_\_

Has a physician treated your child in the last 12 months for an illness or injury?

If so, explain: \_\_\_\_\_

Date of last DPT or Tetanus: \_\_\_\_\_

Does student take any prescribed medications or over-the-counter medications?

If so, explain: \_\_\_\_\_

