STUDENT MEDICAL PERMISSION FORM

(Please print or type.)

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

Address:_____ Sex:____ Student ID:_____
Number & Street City State ZIP

Emergency Information

Parents/Guardian 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: (____) _____

Insurance Company Address: _____
Number & Street City State ZIP

Name of Primary Insured: _____ Group #: _____

Note: Insurance coverage is not required for participation.

Brief Medical History

Special Health Concerns: _____

Asthma: ☐ yes ☐ no

Heart Problem: ☐ yes ☐ no

Diabetes: ☐ yes ☐ no

Allergies: ☐ yes ☐ no

Seizures: ☐ yes ☐ no

Other: _____
(Includes pregnancy, recent surgery, or other chronic conditions)

Current Medications:

Medication:	Dosage per day:
_____	_____
_____	_____
_____	_____
_____	_____

Note: If your child is taking medication regularly, please bring a supply in a labeled container.
(Please Note: Prescription medication requires a current prescription label. Over-the-counter medication must be accompanied by an order from a licensed health care provider.)

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

_____

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: _____

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