

# 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: \_\_\_\_\_