

**2021-2022 Health Information & Medical Release Form**

STUDENT NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_/\_\_\_\_/\_\_\_\_

I, the undersigned, being the parent, legal next-of-kin, or legal guardian of \_\_\_\_\_, hereby authorize any necessary medical treatment for this person while participating in any South-Doyle High School Band functions during the **2021-2022** school year. I also will be responsible for all financial responsibilities during medical treatment.

In regard to such person, I submit the following information:

1. Allergies to foods, medications. If none, write "none". \_\_\_\_\_  
\_\_\_\_\_

2. Special medical problems or health conditions. If none, write "none". \_\_\_\_\_  
\_\_\_\_\_

3. Medication(s) or prescription(s) to be used by student. If none, write "none".

Medication _____	Purpose _____
Medication _____	Purpose _____
Medication _____	Purpose _____

4. In the event that we cannot reach you, do we have permission to give any of the following medicines to your child?  
(Please mark yes or no for each line)

Benadryl	Yes _____ No _____	Tylenol	Yes _____ No _____
Pepto Bismol	Yes _____ No _____	Kaopectate/Imodium	Yes _____ No _____
Advil/Ibuprofen	Yes _____ No _____	Sudafed	Yes _____ No _____
Antacids (Mylanta, etc.)	Yes _____ No _____	Dramamine	Yes _____ No _____

5. My child is prescribed and carries an EpiPen Yes \_\_\_\_\_ No \_\_\_\_\_ an inhaler Yes \_\_\_\_\_ No \_\_\_\_\_

6. Date of last Tetanus shot? \_\_\_\_\_

7. Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

8. Person(s) other than parent or guardian to notify in case of emergency:

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_  
Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

9. Health Insurance Carrier \_\_\_\_\_ Policy Group # \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ ID # \_\_\_\_\_

*I hereby give permission and approval for any and all medical and surgical treatments, including anesthesia and operations which may be necessary and or available to my son or daughter by the attending physician and surgeons. The intention hereof, being to grant authority to administer and perform all and singularly, and procedure which may now or during the course of the patient's care be deemed advisable or necessary. I/we also agree that the patient, when admitted, is to remain in the hospital until his/her physician recommends the patient's discharge. Every effort will be made to contact parent(s) or guardian(s) in advance of treatment, by telephone, in case of injury or illness.*

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

Notary Public \_\_\_\_\_ Date \_\_\_\_\_ Expire \_\_\_\_\_