

MEDICAL RELEASE FORM-LCPS PERFORMING ARTS

A Doctor's Certificate is **NOT** required. (This form is to be completed by parent/guardian-regardless of your age)

STUDENT NAME: _____ **AGE:** _____ **D.O.B.** _____

SS#: _____

Student taking any medication? YES _____ **NO** _____ If yes, list below:

List any allergies: (including food, medicines, etc.): _____

Immunization History: (Give date of most recent booster dosage)

DPT _____ **Tetanus** _____ **Small Pox** _____ **Polio** _____

Measles _____ **Mumps** _____ **Any other** _____

Does student get motion sickness? YES _____ **NO** _____ **If yes, provide Dramamine, etc and list dosage to be taken.**

Does student have any dietary restrictions or considerations that we need to be aware of: (Religious, allergies, vegetarian, etc.):

MEDICAL INSURANCE COMPANY COVERING STUDENT: _____

POLICY NUMBER: _____ GROUP: _____

PRIMARY INSURED MEMBER'S NAME: _____

EMPLOYER OF PRIMARY INSURED MEMBER: _____ PHONE NUMBER _____

SOCIAL SECURITY OF PRIMARY INSURED MEMBER: _____

IN THE EVENT I CANNOT BE REACHED IN AN EMERGENCY, I HEREBY GIVE PERMISSION TO THE DIRECTOR/ CHAPERONES TO SECURE PROPER MEDICAL TREATMENT, AND IF NECESSARY, TO TRANSPORT BY AMBULANCE, HOSPITALIZE, AND TO ORDER INJECTION, ANESTHESIA OR SURGERY FORMYCHILD LISTED ON THIS FORM.

PARENTS'/GUARDIANS' NAME: _____

PLEASE PRINT

PARENTS'/GUARDIANS' SIGNATURE: _____ **DATE:** _____

_____ **DATE:** _____

HOME PHONE: _____ **WORK PHONE:** _____

NEAREST RELATIVE NAME: _____ **PHONE:** _____

STUDENT/FAMILY IS RESPONSIBLE FOR ALL MEDICAL COST INCURRED SURING THIS TRIP!

STUDENT SIGNATURE: _____ **DATE:** _____

WITNESS SIGNATURE: _____ **DATE:** _____