

MEDICAL PERMISSION FORM

(Please print or type)

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

Address: _____ Sex: ____ SSN: ____ - ____ - ____
Number & Street City State ZIP

EMERGENCY INFORMATION

Parents' 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: (____) _____

Address: _____
Number & Street City State ZIP

Name of Insured: _____ SSN of Insured: ____ - ____ - ____

NOTE: Please attach a copy of the insurance card and driver's license of the primary insured person.

BRIEF MEDICAL HISTORY

Special Health Concerns (allergies, etc.): _____

Allergic to any medications? Yes No If yes, please list: _____

Current Medications: _____ Dosage per day: _____

NOTE: If you are taking medication regularly, please bring a supply in a labeled container.

Asthma: yes no Medication: _____
Diabetes: yes no Medication: _____
Epilepsy: yes no Medication: _____
Heart: yes no Medication: _____

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

Are there any prescription or non-prescription drugs that should NOT be administered? _____

The trip advisor(s) may provide my child with: Tylenol Advil Either Neither

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: _____