DSMS BAND Medical Release Form

Student's Name:_____ _____ DOB:_____ Grade:_____

PLEASE ATTACH A COPY OF PARENTS' INSURANCE CARD

Insurance Company:_____ Policy #:_____ Amount of Copay: $_____

Students need to bring any leg, ankle, or foot braces they normally use with them on any trip to prevent injury.

Please fill out items below to alert us of any problems:

ALLERGIES and ASHTMA:

1. Does this child have asthma that has been diagnosed by a doctor? YES_____ NO _____
   If yes, what treatment and or medications have been prescribed?_____
   _____
2. Please list any severe allergies and recommended treatment:
   _____

INJURIES, ILLNESSES, and SURGERIES:

1. List injuries, illnesses, surgeries, and medical problems:

Condition	Age	Hospitalized?

2. Does this problem/condition require special health care at school? YES_____ NO_____

ADDITIONAL INFORMATION:

1. What medications are given daily?_____
2. What medications are given frequently?_____

PHYSICIAN INFORMATION:

Name	Office Phone	Fax

PARENT/GUARDIAN INFORMATION:

FATHER:_____ WORK:_____HOME/CELL:_____

MOTHER:_____ WORK:_____HOME/CELL:_____

It may be necessary to contact you during the school day. If you cannot be reached, we will call the person(s) listed below:

NAME:_____ PHONE:_____

NAME:_____ PHONE:_____

I HEREBY GRANT MY AUTHORIZATION AND CONSENT TO MEDICAL CARE, TREATMENT PROCEDURE, OR PHYSICIAN CONSULTANT DEEMED NECESSARY IN ORDER TO ENSURE THE SAFETY OF SAID CHILD. WE WILL NOTIFY THE SCHOOL IMMEDIATELY IF THE HEALTH STATUS OF SAID CHILD CHANGES.

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE