Medical Release Form

Student's Name_____

Insurance Carrier _____ **Policy Number** _____

Birth Date_____**Male**_____**Female**_____**Grade**_____

Person with whom you reside (circle one)
Both Parents Mother Father Step Parent

Mothers Name_____Phone#_____

Fathers Name_____Phone#_____

Parents Work Phones:

Mother_____Father_____

Cell Phone#'s_____

Address (where student lives) _____

Emergency Contact (not a parent)

Name_____Phone#_____

Relationship to Student_____

Family Doctor _____Phone #_____

Does your son/daughter have any Allergies or Health problems?
Describe and be as specific as possible.

_____

What serious illness, injuries, or operations has he/she had?

describe_____

Regular Medication(s)_____

Parent/Guardian Medical Consent
I hereby give my consent, in the event of injury or illness, for emergency medical treatment, hospitalization or other medical treatment as may be necessary for the welfare of the above named student, by a physician, qualified nurse, certified athletic trainer, and/or hospital during all periods of time in which the student is away from his/her legal residence as a member of an interscholastic activity team/group. Further, I hereby waive, on behalf of myself and the above named student any liability of Kalispell school district #5, its agents or employees, arising out of such medical treatment.

Parent/guardian
Signature_____**date**_____