

# 2010-2011 Medical History and Release Form

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Age \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Mother's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Father's Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Home Phone (\_\_\_\_) \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ Zip \_\_\_\_\_

In case of emergency, notify \_\_\_\_\_ Phone \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_

Family Insurance Co \_\_\_\_\_ Policy # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

IMMUNIZATIONS: \_\_\_\_\_ Tetanus \_\_\_\_\_ Polio Booster \_\_\_\_\_ Measles \_\_\_\_\_ Mumps

Other: \_\_\_\_\_

## PAST MEDICAL HISTORY

Asthma \_\_\_\_\_ Sinusitis \_\_\_\_\_ Bronchitis \_\_\_\_\_ Kidney \_\_\_\_\_ Heart \_\_\_\_\_ Diabetes \_\_\_\_\_

Dizziness \_\_\_\_\_ Stomach Upset \_\_\_\_\_ Hay Fever \_\_\_\_\_ Other \_\_\_\_\_

ALLERGIES: Food \_\_\_\_\_ Insect bites/stings \_\_\_\_\_

Penicillin or other drug (name) \_\_\_\_\_

Poison Sumac, Oak, or Ivy \_\_\_\_\_

Other \_\_\_\_\_

Previous Operations or serious illness \_\_\_\_\_

Any current medications \_\_\_\_\_

Special Diet (name) \_\_\_\_\_

Childhood Diseases: Chickenpox Measles Mumps Whooping Cough \_\_\_\_\_

Any medical needs which your child has, of which adult supervisors should be aware: \_\_\_\_\_

## PERMISSION FOR TREATMENT

My permission is granted for school supervisors to obtain necessary medical attention in case of sickness or injury of my student.

I release and waive, and further agree to indemnify, hold harmless or reimburse the Cobb County School District, the Board of Education, its successors and assigns, its members, agents, employees, and representative thereof, as well as trip supervisors, from and against, any claim which I, any other parent or guardian, any sibling, the student, or any other person, firm or corporation may have or claim to have, known or unknown, directly or indirectly, from any losses, damages or injuries arising out of, during or in connection with the student's participation in the trip or the rendering of emergency medical procedures or treatment, if any.

DATED this \_\_\_\_\_ of \_\_\_\_\_, 2010

\_\_\_\_\_  
Signature of Parent/Guardian NOTARY \_\_\_\_\_

\_\_\_\_\_ Advil (Ibuprofen) \_\_\_\_\_ Aleve \_\_\_\_\_ Tylenol \_\_\_\_\_ Benedryl \_\_\_\_\_ Pepto Bismol/Tums \_\_\_\_\_ Other \_\_\_\_\_

Please initial next to the pain medication(s) that are acceptable for your child to take if he/she requests: