

Student Last Name: _____



MEDICAL RELEASE FORM

The form will not be accepted unless it is completely filled out.

Insurance Information: Please Print Legibly

Candidate's First Name: _____ Last Name: _____
Family Physician: _____ Phone #: _____
Address: _____ City: _____ Zip Code: _____
Insurance Company: _____ Policy #: _____
Hospital Preference: _____ Phone #: _____
Address: _____ City: _____ Zip Code: _____

Medical History: Please Print Legibly

Health Conditions: _____
(e.g. Asthma, Diabetes) ☐ Yes ☐ No If yes, list here: _____
Food Allergies: ☐ Yes ☐ No If yes, list here: _____
Medication Allergies: ☐ Yes ☐ No If yes, list here: _____
Prescribed Medications: ☐ Yes ☐ No If yes, list here: _____
Special Considerations: ☐ Yes ☐ No If yes, list here: _____
Psychological Care: ☐ Yes ☐ No If yes, list here: _____
Pastoral Home Visit: ☐ Yes ☐ No If yes, list here: _____
Medical Restrictions: ☐ Yes ☐ No If yes, list here: _____
Other Medical Information: _____
Date of Last Tetanus Vaccine: _____ Blood Type: ☐ A ☐ B ☐ AB ☐ O

AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S):

As custodian of the aforementioned minor, I grant my authorization and consent for a designated adult to administer general first aid treatment for minor injuries or illnesses. If the injury or illness is severe, I authorize him or her to seek professional emergency personnel to attend, transport, and treat the minor and to issue consent for any medical care deemed advisable by a license medical professional or institution. I authorize the designated adult to exercise best judgment upon the advice of medical or emergency personnel.

Parent/Guardian's First Name: _____ Last Name: _____
Parent/Guardian's Signature: _____ Date: _____