

# WKBA Medical Release Form

## Contact Information

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Parent/Guardian Name

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

\_\_\_\_\_  
Student Birth Date      Age      Gender

\_\_\_\_\_  
Daytime Phone      Evening Phone

### Medical History

	YES	NO
Are you currently taking any medicine or treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Have you been restricted from travel, sports, or exercise for any reason?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever had a severe reaction to a bee sting or insect bite?	<input type="checkbox"/>	<input type="checkbox"/>
Do you suffer from motion sickness?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any known allergies?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any of the following?		
Asthma	<input type="checkbox"/>	Sinus Trouble <input type="checkbox"/>
Hay Fever	<input type="checkbox"/>	Heart Trouble <input type="checkbox"/>
Communicable Disease <input type="checkbox"/>	Diabetes <input type="checkbox"/>	Epilepsy <input type="checkbox"/>

If you answered "Yes" to any of these questions, please explain:

\_\_\_\_\_

### Insurance Information

\_\_\_\_\_  
Insurance Company

\_\_\_\_\_  
Card Holder's Name

\_\_\_\_\_  
Policy #      Group#(If Applicable)

\_\_\_\_\_  
Address to Submit Claims

### Emergency Treatment Authorization

I, \_\_\_\_\_, parent/guardian of \_\_\_\_\_, hereby give WKBA and or its' agents, permission to obtain medical assistance for my student. I also give permission to the Physician selected by WKBA and or its' agents, to provide hospitalization and secure the proper treatment for my student.

Signature \_\_\_\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, \_\_\_\_\_ personally appeared before me, a Notary Public, within and for the State and County aforementioned, and acknowledged that he or she freely and voluntarily executed the same for the purposes stated therein.

SEAL:

Commission Expires: \_\_\_\_\_

\_\_\_\_\_  
Notary Public Signature