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?	☐	☐
Have you been restricted from travel, sports, or exercise for any reason?	☐	☐
Have you ever had a severe reaction to a bee sting or insect bite?	☐	☐
Do you suffer from motion sickness?	☐	☐
Do you have any known allergies?	☐	☐

Do you have any of the following?

Asthma ☐		Sinus Trouble ☐	
Hay Fever ☐		Heart Trouble ☐	
Communicable Disease ☐	Diabetes ☐	Epilepsy ☐	

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 therin.

SEAL:

Commission Expires:_____

_____

Notary Public Signature