

Castle Hills First Baptist School
MEDICAL RELEASE AND PERMISSION FORM

(Complete form in INK)

STUDENT NAME: _____ **DOB** _____

PHYSICIAN NAME _____ Phone _____

Hospital preferred by Physician: _____ Phone _____

 Name of Medical Insurance Company Policy # Phone

DENTIST/ORTHODONTIST NAME _____ Phone _____

Hospital preferred by Dentist: _____ Phone _____

 Name of Dental Insurance Company Policy # Phone

MEDICAL INFORMATION

| Check if student has been diagnosed with any of the following conditions. | | | |
|---|--|---|--|
| Allergic Reactions (medications, food, insects) | | Previous Surgeries | |
| Diabetes | | Handicaps, Mental or Physical | |
| Heart Condition(s) | | Glasses or Contacts (circle) | |
| Anemia | | Visual handicap | |
| Asthma | | Hearing Loss – left ear or right ear (circle) | |
| Seizures/Epilepsy | | Hearing Aid | |
| ADD or ADHD (circle) | | Tubes in ears | |
| Scoliosis | | Other medical condition: | |
| Acanthosis Nigricans | | Other medical condition: | |

Has your child ever been diagnosed with Cystic Fibrosis? Yes _____ No _____

If you checked **any** of the above conditions, please provide details (*treatment, inhalers, and any medications*):

Would any of the above conditions limit his/her participation in our educational program? Yes _____ No _____

If yes, please explain: _____

Will your child need any medication during school hours? Yes _____ No _____ **Students may not carry medications at school.** All medications must remain in the nurse's office. You must fill out appropriate forms and provide medications to the school nurse. Emergency medications can be carried with physician's approval. Please call the school nurse at 377-8437 for more information.

PERMISSION AND RESPONSIBILITY STATEMENTS

I give my permission and approval for the above named child to participate in any athletic team, group or association activities, or field trips supervised by the staff of CHFBS. I hereby authorize the staff of CHFBS to call an emergency ambulance in case of accident or acute illness, and to arrange for necessary emergency medical and surgical care. Any qualified physician called by CHFBS may treat and do whatever is necessary for the health and well being of my child. I also agree to accept responsibility for the cost of above medical services. I assume all risks and hazards incidental to such participation, including transportation to and from activities, and I do hereby waive, release, absolve, indemnify and agree to hold harmless the local Inter-Parochial League, school, organizer, sponsors, supervisors, participants, and persons transporting my child, whether the result of negligence or any other cause, except to the extent and amount covered by accident or liability insurance. I understand that it is my responsibility to keep the school informed of any changes to the above information throughout the school year. I give my permission for medical information listed on this form to be shared with the appropriate school personnel.

PARENT/GUARDIAN SIGNATURE

PLEASE PRINT NAME

DATE