

MEDICAL INFORMATION

Student Name _____
(print) Last First MI

Address _____ City _____ State _____ Zip _____

Home Phone () _____ Work Phone () _____

Parent/Guardian _____

Name and phone number of Relative _____ () _____

Relationship to student _____

Additional Emergency Contacts

Name _____ Phone () _____

Name _____ Phone () _____

List additional contacts on the back of this form.

Name of Physician _____

Physician's Phone () _____

Insurance Carrier _____ Phone () _____

Insurance Policy # _____

Important medical information (allergies, alerts, current medication, etc.)
Be certain to bring needed medication along on trips.

May we administer aspirin to your child? Yes___ No___ Tylenol? Yes___ No___
Upset stomach medicine? Yes___ No___ Bendaryl? Yes___ No___ Ibuprofen Yes___ No___

In the event of a medical emergency and if I cannot be contacted, I hereby give permission for my child to receive appropriate medical treatment. I also hereby release Spring Branch Independent School District officials, chaperones, and directors from any liability for any actions taken in the normal course of their duties.

Signature of Parent/Guardian _____

Subscribed and Sworn Before Me

This ___ Day of _____, _____

Date _____

Notary Public