BISHOP SNYDER HIGH SCHOOL
PARENT/GUARDIAN MEDICAL RELEASE

Student's Name:_____ Date of Birth:_____

Parent/Guardian Name:_____

Home Address:_____ Home Phone:_____

MEDICAL MATTERS: I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child.

Of the following statements pertaining to medical matters, sign only in accordance with your wishes:

EMERGENCY MEDICAL TREATMENT: In the event of an emergency, I hereby give permission to Bishop Snyder High School employees, volunteers, or representatives to seek medical treatment for my child (named above).

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by Bishop Snyder representatives or volunteers to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child (named above).

In the event of an emergency, if you are unable to reach me at the above number contact:

Name and relationship:_____ Phone:_____

Family Doctor:_____ Phone:_____ Insurance/Policy Number_____

My child's medications/dosages:

Rx:_____Dosage:_____ Doctor:_____ Rx:_____Dosage:_____ Doctor:_____
Rx:_____Dosage:_____ Doctor:_____ Rx:_____Dosage:_____ Doctor:_____
Rx:_____Dosage:_____ Doctor:_____ Rx:_____Dosage:_____ Doctor:_____

PLEASE BE CERTAIN YOUR CHILD HAS AN ADEQUATE SUPPLY OF ALL REQUIRED MEDICATIONS FOR THIS ACTIVITY.

Describe medical conditions (allergies, diabetes, etc.) and/or physical disabilities:

_____

_____

I make the following exceptions(s):_____

_____ _____
Signature of Parent/Guardian Date

OTHER MEDICAL TREATMENT: In the event it comes to the attention of Bishop Snyder volunteers or representatives that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, or diarrhea, I hereby give permission for over-the-counter medication to be administered to my child according to directions.

_____ _____
Signature of Parent/Guardian Date