

# MOODY ATHLETIC DEPARTMENT MEDICAL RELEASE FORM

Date \_\_\_\_\_ Name \_\_\_\_\_ Grade \_\_\_\_\_

Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address \_\_\_\_\_ Home phone number \_\_\_\_\_

Mother's Name \_\_\_\_\_ Work Number \_\_\_\_\_ Cell \_\_\_\_\_

Father's Name \_\_\_\_\_ Work Number \_\_\_\_\_ Cell \_\_\_\_\_

Emergency #'s: 1<sup>st</sup> call \_\_\_\_\_

2<sup>nd</sup> call \_\_\_\_\_

3<sup>rd</sup> call \_\_\_\_\_

## HEALTH INFORMATION:

Allergies:  Medicine  Bees  Ants  Food/other \_\_\_\_\_

Medical conditions (check if you have the following):

Asthma  Diabetes \_\_\_\_\_ Pump \_\_\_\_\_ injection(s) \_\_\_\_\_ pills \_\_\_\_\_

Epilepsy (seizures)  bleeding disease  Surgeries \_\_\_\_\_

Eye problem(s)  Ear problem(s)  Nose bleeds  other \_\_\_\_\_

List any medication that student takes on a regular basis \_\_\_\_\_

We may only give medication that you have provided in original bottle. You have filled out a form, and doctor for this medication. I give permission to have my child treated by the medical designate on athletic trip(s), athletic camps, or games. I understand that all reasonable precaution will be taken for my child's safety, and I will not hold the school or designate responsible for any illness or unforeseen accident.

I, the undersigned, do hereby authorize the official/health care designate of St. Clair County schools to contact directly the person(s) named on this paper, to render such treatment as may be deemed necessary in an emergency for the health of my child. In the event physician(s), or other person(s) named on this paper, or parents are unable to be reached, I give permission to transport my child to the nearest medical facility. **Every** attempt will be made to reach the parent/guardian or emergency person listed above.

I, the undersigned do also hereby give my permission for my child to travel with the \_\_\_\_\_ Moody athletic department to their designation, games, events, etc. I will not hold the high school, athletic department, or St. Clair County School System responsible for any accident, etc.

Signature of Parent/Guardian \_\_\_\_\_

Child's Doctor \_\_\_\_\_ Doctor's address \_\_\_\_\_

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

Hospital of choice \_\_\_\_\_