



2 – 09 Field Trips and Excursions

Exhibit III

STUDENT MEDICAL RELEASE FORM

Student's Full Name: _____ Age: _____ Date of Birth: _____

Address: _____

Mother's/Guardian's Name: _____ Phone: (home) _____
(work) _____

Father's/Guardian's Name: _____ Phone: (home) _____
(work) _____

Emergency Name: _____ Phone: (home) _____
(Other than parent or guardian) (work) _____

Family Physician's Name: _____ Office Phone: _____

Alberta Health Care # (optional): _____ Health Plan (if any): _____
Policy #: _____

Travel Insurance (if any): _____ Policy # (if any): _____
Phone: _____

Medical Conditions

Does your child have conditions that we should be aware of: (Y for yes, N for no or N/A for not applicable)

- | | | |
|-----------------------------|-----------------------|----------------------|
| _____ Asthma | _____ Ears | _____ Menstruation |
| _____ Bronchitis | _____ Nose | _____ A.D.D. |
| _____ Breathing | _____ Diabetes | _____ Heart Murmur |
| _____ Cough | _____ Hypoglycemia | _____ Blood Pressure |
| _____ Stomach | _____ Headache | _____ Cancer |
| _____ Intestines | _____ Seizures | _____ Bones |
| _____ Kidneys Urinary Tract | _____ Dizziness | _____ Other _____ |
| _____ Arthritis | _____ Motion Sickness | |
| _____ Eyes | _____ Emotions | |

If you answered YES to any of the above medical conditions, please fill in the appropriate spaces on page 2. Include all pertinent information: dates of onset and last occurrence; frequency; what triggers or causes the problem; usual symptoms; prevention and treatment. PRESCRIBED MEDICATIONS THAT YOUR CHILD WILL BE ON should be listed under prevention or treatment.



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Medical Information

Medical Condition	FROM Month/Yr.	TO Month/Yr.	Frequency	Caused or Aggravated by	Usual Symptoms	Prevention	Treatment

Allergies

Is your child allergic to:

- | | | | |
|-------------------------------------|---------------------------------------|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Ampicillin | <input type="checkbox"/> Insect Stings |
| <input type="checkbox"/> Tylenol | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Erythromycin or Ilosone | <input type="checkbox"/> Foods |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Amoxil | <input type="checkbox"/> Other Medications | <input type="checkbox"/> Environmental Things |

If your child has allergies, please list them below and include symptoms and treatment

Allergy	Symptoms	Treatment	Allergy	Symptoms	Treatment

Do you know of any health factor that makes it advisable for your child to follow a limited program of physical activity, or from participating in any activities? If yes, please explain. Mention any recent surgery, illness, broken bones, injuries, physical conditions, allergies or other reason.

Any other pertinent medical information: _____

Do we have permission to administer to your child, if necessary:

- | | |
|--|---|
| <input type="checkbox"/> Tylenol | <input type="checkbox"/> Robitussin Cough Syrup |
| <input type="checkbox"/> Imodium (antidiarrheal) | <input type="checkbox"/> Antibiotic Ointment (on cuts or scrapes) |
| <input type="checkbox"/> Chlortripolon (antihistamine) | <input type="checkbox"/> Polysporin Eye Ointment |
| <input type="checkbox"/> Polysporin Ear Drops | |

Parents/Guardians' Authorization: This health information is correct to the best of my/our knowledge and the student herein described has my/our permission to engage in all activities unless other wise noted by me/us. I/we give permission to the physician or hospital, selected by the teacher or any adult in charge, to secure proper treatment and to order medications, injections, anesthesia or surgery for my/our child. Every effort will be made to contact the parent(s)/guardian(s). I/we also understand that any medical expenses not covered by Alberta Health Care will be paid for by me/us, the student's parent(s)/guardian(s).

Signature (Mother/Guardian): _____ Date: _____

Signature (Father/Guardian): _____ Date: _____