Emergency Release Form

for a class visit during the regular academic year.
To be completed by the parent/guardian of the applicant.

Applicant's Dates of Visit______________________________ Grade Level ___________

AUTHORIZATION AND CONSENT TO PROVIDE EMERGENCY MEDICAL CARE

(Student)__________________________________ ☐ Male ☐ Female is my child, and I am his/her Custodial Parent or Legal Guardian. In case of accident, illness, injury during the school day or on a school-sponsored field trip, school personnel will make every effort to obtain emergency medical care. In such a case where it is impossible to reach us, I/we hereby authorize The Winston School and its designated representatives to seek and obtain emergency medical care for above student, which may include emergency room treatment, hospitalization, surgery, securing the services of medical personnel, x-rays, and/or medications. I/we hereby assume financial responsibility for these costs.

Hospital Preference ____
Physician ____ Phone ______________________
Dentist ____ Phone ______________________

My child ____**IS** ____**IS NOT** covered by medical insurance.
Insurance Company: ____
Primary Insured: ____ SS#:_______________________
Relation to Student: ______________________________ Pre-certification Phone # ______________
Policy # ____ Group # _____________________

Medical History: My child ___**does** ___**does not** wear contact lenses.
Date of Birth __________________________ Date of last tetanus shot ____________________
Drug allergies ____
Other allergies ____
Medications taken daily ____
Pertinent health information ____
____

Student lives with ____
Home address ____ Phone ______________
City ____________________________________ State __________________ Zip______________
Mother/Guardian's Name ____
Employer ____
Business address ____ Phone ______________
City __________________________________ State __________________ Zip ________________
Cell phone __________________________ Fax __________________________

Father/Guardian's Name ____
Employer____
Business address ____ Phone ______________
City ____________________________________ State __________________ Zip ______________
Cell phone _____________________ Fax ___________________

FIRST AID & MEDICATIONS: (CHECK ONE SPACE BELOW)

I am giving my permission for the designated Winston School representatives to provide my child with routine first aid. They may also give my child the medications I have checked or listed below. (Strike any medications that are not acceptable to you.)

_____My child **may** take Advil, Tylenol, antacids, Benadryl, Sudafed, cough drops, or throat lozenges.
_____My child **may not** take any medication at school unless sent by me.

____ ____________________________
Signature of parent or guardian Date