Texas Association of Student Councils

MEDICAL RELEASE AND PERMISSION FORM

(Please print legibly)

Name:		**Home Phone:**	
Address:		**City/State/Zip:**	
Gender: (M or F)		**Birthdate: (M/D/Y)**	

EMERGENCY INFORMATION:

Parent/Guardian:		**Work Phone:**	
Other Emergency Contact:		**Phone:**	
Physician's Name:		**Phone:**	
Who is responsible for medical payments? Name:			
Phone Number:			
If Insured, Medical Insurance Co. Name:			
Address:		**City/State/Zip:**	
Name of Insured:			

BRIEF MEDICAL HISTORY

Special Health Concerns (allergies, etc)			
Allergic to any medications?	**Yes:** ☐ **No:** ☐	**If yes, please list:**	
Current Medications:		**Dosage per day:**	
NOTE: If you are taking medication regularly, please bring a supply in a labeled container.			
Asthma:	**Yes:** ☐ **No:** ☐	**Medication:**	
Diabetes:	**Yes:** ☐ **No:** ☐	**Medication:**	
Epilepsy:	**Yes:** ☐ **No:** ☐	**Medication:**	
Heart:	**Yes:** ☐ **No:** ☐	**Medication:**	
Should Activity be Restricted?	**Yes:** ☐ **No:** ☐	**If Yes, Please explain:**	
Are there any prescription or non-prescription drugs that should NOT be administered?			
The retreat staff may provide my child with:	☐ **Aspirin** ☐ **Tylenol** ☐ **Advil** ☐ **Either** ☐ **Neither**		

I, the parent or legal guardian of _____ (my child), authorize and direct TASC District 3 Staff, or school advisor, to obtain medical care for my child in the event such care is reasonably necessary. I understand that, if possible, I will be contacted in the event my child requires medical attention. I grant to a licensed health care provider or accredited hospital permission to perform any reasonably necessary medical and/or surgical procedures that are essential for the treatment of my child and agree to be responsible for payment for such care. I release TASC District 3, the school advisor, and agents from any damages, liability, or loss resulting from the exercise of discretion in securing in good faith medical care for my child.

Parent or Guardian Signature:		**Date:**	