

MEDICAL INFORMATION

Student Name _____
Last First Middle

Physician's Name _____

Physician's Phone Number _____ Date of last DPT/Tetanus shot _____

List ANY Health Concerns or Activity Restrictions

List ANY Allergies

If your child becomes sick or is injured, we will make every attempt to contact you, or anyone you list as an emergency contact.

Emergency contact(s):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

In the event we are unable to contact you, please indicate which of the following you give ELCA permission to administer to your child:-

Ibuprofen (Advil/Motrin)	Yes / No (circle one)	Tums	Yes / No
Benadryl -- oral	Yes / No	Cough drops	Yes / No
Benadryl -- cream	Yes / No	Acetaminophen(Tylenol)	Yes / No
Neosporin -- cream	Yes / No		

MEDICAL RELEASE

I hereby certify that the student is in good health and may participate in all activities unless otherwise stated herein. In case of emergency, I give permission for the student, to which I am parent or guardian, to be given emergency treatment at any hospital reasonably accessible and to be transported by 911/EMS services if need be.

Parent/Guardian Signature

Relationship

Date