

# Home of Fine Arts Connection Incorporated

## Medical Release Form *To be filled out by parent*

Student Name \_\_\_\_\_

Date of birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Grade \_\_\_\_\_

Name of parent \_\_\_\_\_

Home telephone \_\_\_\_\_ Cell telephone \_\_\_\_\_

Home Address \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship to student \_\_\_\_\_

Telephone \_\_\_\_\_

Does the student have any medical conditions (i.e., diabetes, asthma, allergies, etc.) that the staff should be aware of? (yes or no) \_\_\_\_\_. If yes, please explain

\_\_\_\_\_

Does the student have any medical conditions that would prohibit full participation in the courses or programs that the student is in enrolled in? (yes or no) \_\_\_\_\_. If yes, please explain

\_\_\_\_\_

\_\_\_\_\_  
(physician name)

\_\_\_\_\_  
(phone number)

Do we have your permission to administer acetaminophen (Tylenol) or ibuprofen to your child if needed? (yes or no) \_\_\_\_\_ If so, dosage \_\_\_\_\_

*The information that is provided by me in this medical release is, to the best of my knowledge, accurate and true. As indicated by my signature below, I authorize staff personnel to consent to any emergency treatment of my minor child (named above) which shall, in my absence, be deemed necessary. This shall include examination, anesthesia, medical diagnosis, surgery, or treatment and/or hospital care of the minor child under the general or special supervision and upon the advice of a physician or surgeon licensed to practice medicine in the United States of America. This authorization shall be valid during the present school year only.*

\_\_\_\_\_  
(parent/guardian signature)

\_\_\_\_\_  
(date)