

Parents: Please fill this form out carefully and completely. This is the Medical Form required by GISD and must be completed before any child participates in any GISD extra-curricular function.

GISD SPECIAL SITUATIONS STUDENT MEDICAL INFORMATION FOR TRIPS

Event: _____ School: _____ Today's Date _____

Student Name: _____ Birthdate: _____

Home Phone: _____ Social Security #: _____ Gender: male female

Current Address: _____

Father's Name: _____ Street/P.O.Box _____ City _____ State _____ Zip _____
Home Phone: _____ Work: _____ Cell _____

Mother's Name: _____ Home Phone: _____ Work: _____ Cell _____

Emergency Contact: _____ Phones: _____

Health Insurance Company: _____ Member Name: _____

Member I.D. # _____ Group # _____ Policy #: _____

Please list your preferred provider (Clinic, Doctor, HMO, etc.) List the provider's name, address, and phone number. _____

Please indicate medical alerts such as allergies, contact lenses, chronic illness such as Asthma, Diabetes, etc.

STUDENT HEALTH HISTORY AND RECORD

NAME: _____ AGE: _____ GRADE: _____ DATE: _____

ADDRESS: _____ PHONE: _____

HEALTH HISTORY

Please list any allergies to medication, food, or other allergens, and type or reaction: _____

Does student have any chronic health conditions? Yes ___ No ___ Date: _____ Please List _____

Has student ever been hospitalized? Yes ___ No ___ Date: _____ Reason: _____

Does student take any medications on a regular basis? Yes ___ No ___ Please list medication, dose, and times taken, and reason: _____

Are you concerned about any health concerns for the student at this time? Yes _____ No _____

What are they? _____

Parent Signature: _____ Date _____

MEDICATION PERMISSION

I give my permission for GISD staff, or the nurse on duty, to administer the following medications while on any band trip. I understand that no other medications will be made available or administered to my child by GISD staff on any band trip. All medications will be brought in original containers and all prescription medications will be brought in a pharmacist labeled bottle.

Name of medication	Strength of medication	Dose	Frequency	Reason for medication
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Parent Signature: _____ Date: _____

IMPORTANT INSURANCE NOTICE

Catastrophic Health Insurance is available through the Georgetown ISD. This is especially recommended for any students involved in high-risk activities like athletics or gymnastics. It is also recommended that students have personal health insurance.

RELEASEES AND WAIVERS

Signify your approval by writing your initials in the space before the statement(s) and signing below.

- _____ 1. In the event of an injury or illness to the above named student, I hereby authorize a representative of GISD to secure emergency medical treatment for the above named student from any healthcare provider.
- _____ 2. I understand that I will be financially responsible either with personal health insurance or other means, for medical treatment needed by my child.
- _____ 3. I certify that the information provided on this form is true and correct to the best of my knowledge.
- _____ 4. I hereby authorize the release of medical records and information as well as medical insurance information to the healthcare providers as needed for the treatment of injuries and illness to my child.
- _____ 5. I hereby authorize GISD staff, or nurse on duty, to administer the medications listed on this page of the document. I understand that the GISD will not provide medications for my child on this trip. I release from liability GISD, its staff, and nurses for any medication reactions or medication allergy that my child experiences.
- _____ 6. I hereby agree to bring this information up to date, as the need arises, before any band trip that might require medical attention.
- _____ 7. I hereby give my permission for GISD to use photographs of my student for publication in newspapers, web pages, and/or other media.

Parent's Signature _____ Date: _____

Proof of I.D _____ Expiration Date: _____