

FORT BEND I.S.D. MEDICAL INFORMATION CERTIFICATE

PLEASE PRINT

Student's Name _____ Sex M F Age _____
Last First Middle (Circle one)

Parent's Name _____ Student's Date of Birth _____

Address _____
Street City State Zip Code

Parent's Telephone _____ Emergency Telephone _____ Family Physician _____

School _____ Grade _____ Telephone _____

Insurance Company _____ Policy Number _____

TO BE COMPLETED BY PARENT OR GUARDIAN

Does the student have previous history of:

	Yes	No		Yes	No
Bleeding tendencies	<input type="checkbox"/>	<input type="checkbox"/>	Contact Lenses/ Glasses	<input type="checkbox"/>	<input type="checkbox"/>
Head injuries, seizures, unconsciousness, concussion, or convulsion	<input type="checkbox"/>	<input type="checkbox"/>	Now under a physician's care?	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Name of Physician _____		
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Date of last Tetanus shot? _____		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Allergy	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Neck injury	<input type="checkbox"/>	<input type="checkbox"/>
Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Bone and/or joint injury or disease	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease and/or injury	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Kidney, Lung, or Eye removed or nonfunctioning	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Surgical operation	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Allergy to medication	<input type="checkbox"/>	<input type="checkbox"/>
Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>	Is student taking medication regularly?	<input type="checkbox"/>	<input type="checkbox"/>

Explain any Yes" answers: _____

Please list all medications and any illnesses not listed above requiring medications being taken at the present time:

I hereby consent for medical care to be given to _____ in case of any emergency.

Parent/Guardian

Date

SPONSOR / FIELD TRIP _____

RELEASE FORM - TRAVEL

I, _____ (Student - Please Print) do pledge to uphold all student policies and the high standards of the Fort Bend ISD. I understand that I am governed by the same rules on any sponsored trip or activity as if I am at school. I understand that possession of, having used or being under the influence of drugs and/or alcohol are prohibited and the school's authority to enforce the policy includes the right to inspect personal luggage, lodging accommodations, transportation vehicles, etc. I understand that my infraction will be dealt with according to F. Bend ISD Code of Conduct guidelines and may result in my being sent home immediately at my parents'/guardians' expense from a trip or activity.

(Student Signature) _____ (Age) _____ (Date of Birth)

I, _____, being the legal parent/ guardian of _____, a member of Austin High School student body, give my full permission for my child/ward to attend any sponsored and/or related event or activity. Furthermore, I do hereby release from any and all claims, demands, actions, or causes of action, due to death, injury or illness, the Fort Bend ISD, Austin High School and their administrative/faculty personnel.

I further consent to the treatment of _____, my son/daughter/ward by the medical facilities of a Public Health Service or civilian physician/medical facility as required in the event of any illness/accident existing. This consent includes any medical, anesthesia or surgical treatment or hospital services rendered under the general and special instructions of the attending physician or other physicians assigned to his or her care.

MEDICAL INFORMATION

My son/daughter/ward has been determined to have the following allergies:

He/She requires medication for the treatment of _____.

Our family doctor is _____. In case of emergency, he/she may be reached at _____. We are covered by hospitalization. The name of our insurance company is _____.

(Witness other than relative)

(Signature of Parent)

(Address)

(Address)

(City, State and Zip Code)

(Home Phone) _____ (Work or cell Phone)

PROCEDURE FOR STUDENT MEDICATION WHILE ON SCHOOL TRIPS

Dear Parents / Guardians, Please fill out **ALL** sections below. **You must sign below.**

PARENTAL PERMIT TO ADMINISTER MEDICATION ON SCHOOL TRIP

PART I:

We will have a first aid kit available with Advil and Tylenol available for headaches, pain or fever.

I (parent/guardian – print name) _____,

consent to my child (print name) _____

receiving the following for pain or fever (**you must check one**):

Advil _____

Tylenol _____

I refuse consent: _____

PART II:

If your child takes medicine on a regular basis, his/her medicines will be administered by _____ at their usual times while on our trip. I will send medications to school in a sealed plastic bag, in the original containers and with this signed permission slip. _____ **Does not apply**

PART III - Other Medications:

Student Name _____ **Does not apply**

Name of medication: _____

Time(s) to be given: _____ Dosage: _____

Reason for medication: _____

Second medication:

Name of medication: _____

Time(s) to be given: _____ Dosage: _____

Reason for medication: _____

Please complete another form for any additional medications.

Parent/Guardian signature: _____ Date: _____