**Texas Association of Student Councils**

**MEDICAL RELEASE AND PERMISSION FORM**

(Print or click and type into table cells.) Advisors, return a copy of this to the director at onsite registration and keep a copy for travel.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name:** |  | **Home Phone:** |  | |
| **Address:** |  | **City/State/Zip:** |  | |
| **Gender: (M or F)** |  | **Birthdate: (M/D/Y)** | |  |
| **Workshop Attending:** |  | **Workshop Dates:** | |  |

**EMERGENCY INFORMATION:**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Parent/Guardian:** | |  | | | **Cell Phone:** |  | |
| **Other Emergency Contact:** | |  | | | **Cell Phone:** |  | |
| **Physician’s Name:** | |  | | | **Phone:** |  | |
| **Who is responsible for medical payments? Name:** | | | |  | | | |
| **Best phone Number(s):** |  | | | | | | |
| **If Insured, Medical Insurance Co. Name:** | | |  | | | | |
| **Address:** |  | | | | **City/State/Zip:** | |  |
| **Name of Insured:** |  | | | | | | |
| **NOTE: Please ensure that the student travels with an insurance card. If this is not possible, attach a copy of the insurance card of the primary insured person. If a student is uninsured, it will be the responsibility of the school advisor to assume full payment for services if necessary.** | | | | | | | |

**BRIEF MEDICAL HISTORY**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Special Health Concerns (allergies, disability, etc.) Please inform the director of these needs at least 3 weeks prior to workshop.** | | | | | | | |  | | | | | | |
| **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, explain:** | | |  | | |
| **Are there any prescription or non-prescription drugs that should NOT be administered?** | | | | | | | | | | | | |  | |
| **The workshop staff may provide my child with:** | | | | | | **Aspirin  Tylenol  Advil  Either  Neither** | | | | | | | | |

I, the parent or legal guardian of (my child), authorize and direct the Texas Association of Student Councils 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, its employees, 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:** |  |