St. Margaret's Episcopal Church
31641 La Novia,
San Juan Capistrano, CA 92675
Phone (949) 661-0110

Grade: _____
Last Name: _____
First Name _____

Medical Release

Full Legal Name: _____ **Home Phone**_____

Preferred Name:_____ **Gender:** _____ **Birth Date:**_____ **Cell Phone:** _____

Street Address:_____ **City:**_____ **St:**____ **Zip**:_____

Physician Name: _____ Physician Phone :(____)_____

Insurance Company: _____ Policy #:_____

Group #: _____ Insurance Phone :(____)_____

Insurance Street Address:_____ City:_____ St:____ Zip:_____

Medical History (check when appropriate)

Date of last tetanus booster: ____-____-____ (Due every 5-10 years)

Will your child be taking prescribed medication while at church? □ Yes □ No If yes, list medication, dosage, and when taken:_____

Special health problems □ Yes □ No If yes, diagnosis:_____

Recent surgery/injury □ Yes □ No If yes, list with dates:_____

Serious allergies/foods/meds □ Yes □ No Describe:_____
Treatment:_____

Bee sting allergic reaction □ Yes □ No # of times stung:___ Reaction:_____
Treatment:_____

Seizures □ Yes □ No Describe:_____
Treatment:_____

Asthma □ Yes □ No Treatment:_____
□ Yes □ No Inhaler will be provided to Nurse's Office (must be accompanied by physician order)

Diabetes □ Yes □ No Treatment:_____

History of migraine □ Yes □ No Treatment:_____

Heart condition □ Yes □ No Diagnosis:_____

Check Consent for: □ Tylenol □ Advil □ Sudafed □ Benadryl □ Pepto Bismol (administered by nurse)

All medication must be in the properly labeled pharmaceutical container. Requests for the administration of prescription medication at school or on a school-related function must be accompanied by the physician's order.

I (we) the undersigned parent (parents) of the above student, a minor, do hereby give permission for him/her to go on any school sponsored and supervised trips. This blanket authorization takes the place of a parent's signature on permission slips for individual trips. I (we) also authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis and treatment, and emergency hospital care which is deemed advisable by and to be rendered under the general supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act and the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Health or of any similar agency of any State to which a school sponsored and supervised trip is taken. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required but is given to provide authority and power to render care which the before mentioned physician in the exercise of his/her best judgment may deem advisable. Further it is understood that the school shall attempt to contact the undersigned prior to treatment being rendered, but that any of the above treatment will not be withheld if the undersigned cannot be reached. Finally it is understood that for the safety of the student the information contained herein will be provided to the faculty, administrators, and/or coach accompanying the student on any school sponsored and supervised trip.

Parent/Guardian's Signature _____ Date _____