

STUDENT RELEASE INFORMATION

NAME _____ RELATIONSHIP _____

PHONE _____ OTHER _____

NAME _____ RELATIONSHIP _____

PHONE _____ OTHER _____

NAME _____ RELATIONSHIP _____

PHONE _____ OTHER _____

In the event I cannot be reached if my child becomes ill or injured while at school or during an emergency, I hereby authorize this facility to contact and allow my child to leave ONLY with the persons named above.

Signature of Parent or Guardian

Date

CHILD'S MEDICAL HISTORY

We are required to obtain a copy of your child's shot record in addition to the following health information.

ALLERGIES _____

**PREVIOUS
ILLNESS/INJURIES** _____

HOSPITALIZED IN THE PAST 12 MONTHS: Yes _____ **No** _____

**IF YES, PLEASE
EXPLAIN** _____

**EXISTING
ILLNESS** _____

LONG TERM PRESCRIPTION MEDICATION _____

ANY ADDITIONAL INFORMATION _____

