



**ANNUAL MEDICAL RELEASE FORM**  
**School Year 2020-2021**

Student Name \_\_\_\_\_ School \_\_\_\_\_

Birthdate \_\_\_\_\_ Grade \_\_\_\_ Teacher/Advisory \_\_\_\_\_

Home Address \_\_\_\_\_

Name of Parent or Guardian \_\_\_\_\_

Daytime Phone Number(s) \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Emergency Contact Daytime Phone Number \_\_\_\_\_

**MEDICAL HISTORY**

**Medical problems we should know about?** Asthma, allergies, seizures, heart, diabetes, eyes, ears, etc

Explain \_\_\_\_\_

Should any drug (penicillin, sulfa, etc.) be avoided? Yes No \_\_\_\_\_

Are there any allergies (Food, Latex, bee stings, etc.)? Yes No Student has an Epi-Pen Yes No

Medications child takes every day at home? \_\_\_\_\_

Medications student takes every day at school? \_\_\_\_\_

**\*\*Any student that needs prescription medications at school must follow the district policy which requires parent and physician signature. Forms are available in the health office or at [www.isd518.net](http://www.isd518.net). Signed forms are required before medication can be administered.**

Medications child takes as needed (Inhaler, Neb, etc.)? \_\_\_\_\_

Are immunizations up to date? Yes No (Please verify with School Health office)

Name of Family Doctor/Clinic \_\_\_\_\_

Health information will be kept confidential and may be shared with school staff and bus drivers. I hereby give permission to the staff of Independent School District 518, Worthington, MN to give and receive immunization information with my child's doctor, medical clinic, or public health and to seek immediate medical attention for the child named above. I hereby give permission to the physician to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for my child, as named above. I will assume all insurance and medical expenses for my child.

\_\_\_\_\_  
(Date)

\_\_\_\_\_  
(Signature of Parent or Guardian)

12/15wd