GCMS MIDDLE SCHOOL MEDICAL RELEASE FORM

STUDENT NAME: _____

STUDENT AGE: _____

STUDENT BIRTHDATE (MONTH, DATE, YEAR): _____

STUDENT ADDRESS: STREET _____ CITY _____
_____ COUNTY _____

NATURAL PARENT(S) OR LEGAL GUARDIAN(S) RESIDING WITH AND HAVING LEGAL CUSTODY OF STUDENT:

_____

I (WE) AUTHORIZE ANY COACH OF THE GCMS SCHOOL DISTRICT, COUNTY OF FORD, STATE OF ILLINOIS, TO CONSENT TO ANY X-RAY, EXAMINATION, ANESTHETIC, MEDICAL OR SURGICAL DIAGNOSIS OR TREATMENT, AND HOSPITAL CARE TO BE RENDERED TO THE MINOR UNDER GENERAL OR SPECIAL SUPERVISION, AND ON THE ADVICE OF ANY PHYSICIAN OR SURGEON LICENSED TO PRACTICE IN THE STATE OF ILLINOIS, WHEN THE NEED FOR SUCH TREATMENT IS IMMEDIATE, AND WHEN EFFORTS TO CONTACT ME (US) ARE UNSUCCESSFUL.

_____ _____

SIGNATURE OF PARENT OR GUARDIAN DATE

STUDENT'S DOCTOR: _____

STUDENT'S ALLERGIES: _____

PARENT'S DOCTOR: _____

MEDICINE(S) STUDENT IS TAKING: _____

OTHER MEDICAL CONSIDERATIONS OR SPECIAL INSTRUCTIONS (OPTIONAL) _____