

## Medical Release Form

Parents' Names:	Parents' Telephone Number (area code required)
Participant's Name (First, Last) as it should appear on name badge:	
Participant's Home Address:	School: KEYA PAHA COUNTY SCHOOL
City:                      State:                      Zip Code	Mailing address of school: P.O. Box 219
Home Telephone Number (area code required)	City:                      State:                      Zip Code: Springview                      NE                      68778
Age:                      Date of Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female	School telephone Number (area code required): ( 402 ) 497 -3501
Check one: <input type="checkbox"/> Student <input type="checkbox"/> Teacher (Sponsor, Coach) <input type="checkbox"/> Administrator <input type="checkbox"/> Staff	

### Emergency & Medical Information

Name of Person to Contact in event of emergency:	Name of person responsible for Participants Medical Bills:
Contact Person's home phone Number (area code required):	Participant's Relationship to Person responsible for Medical Bills:
Contact Person's work phone (with area code):	Participant: Do you have a history of Allergies? Check one: No <input type="checkbox"/> Yes <input type="checkbox"/>
Name of Family Physician:	Participant: Do you have a history of a Heart Condition? Check one: No <input type="checkbox"/> Yes <input type="checkbox"/>
Physician's phone number:	Participant: Do you have a history of Diabetes? Check one: No <input type="checkbox"/> Yes <input type="checkbox"/>
Name of Insurance Company:	Participant: Do you have a history of Asthma? Check one: No <input type="checkbox"/> Yes <input type="checkbox"/>
Name of Insured:	Participant: Do you have a history of Epilepsy? Check one: No <input type="checkbox"/> Yes <input type="checkbox"/>
Insured's Plan Number:	Participant: Do you have a history of Rheumatic Fever? Check one: No <input type="checkbox"/> Yes <input type="checkbox"/>
Insured's Group Number:	Participant: Do you have other existing condition? Check one: No <input type="checkbox"/> Yes <input type="checkbox"/>
Insurance Company's phone Number for Member Services:	If yes, please explain:
Insurance Company's phone Number for Precertification:	If taking medication please provide description:
Does Participant have health Insurance: check    No <input type="checkbox"/> Yes <input type="checkbox"/>	Participant: when did you last have a tetanus shot: Date:
Check yes if participant has a disability that meets criteria specified in the Americans with Disabilities Act (ADA) <input type="checkbox"/> Yes	

\_\_\_\_\_  
Participant's Signature

\_\_\_\_\_  
Parent/Guardian Signature if under age 18

# Refusal to consent form:

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities. to take no action or to:

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Date

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Signature of Parent/Guardian