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: ☐ Male ☐ Female	School telephone Number (area code required): (402) 497 -3501
Check one: ☐ **Student** ☐ **Teacher (Sponsor, Coach)** ☐ **Administrator** ☐ **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 ☐ Yes ☐
Name of Family Physician:	Participant: Do you have a history of a Heart Condition: Check one: No ☐ Yes ☐
Physician's phone number:	Participant: Do you have a history of Diabetes? Check one: No ☐ Yes ☐
Name of Insurance Company:	Participant: Do you have a history of Asthma? Check one: No ☐ Yes ☐
Name of Insured:	Participant: Do you have a history of Epilepsy? Check one: No ☐ Yes ☐
Insured's Plan Number:	Participant: Do you have a history of Rheumatic Fever? Check one: No ☐ Yes ☐
Insured's Group Number:	Participant: Do you have other existing condition? Check one: No ☐ Yes ☐
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 ☐ Yes ☐	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) ☐ 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:

______________________ ____

Date Signature of Parent/Guardian