HOCKINSON AFTER SCHOOL ADVENTURES PROGRAM
MEDICAL INFORMATION

Date:_____

_____

Student's Name: (Last) (First) (Middle) Birth Date of Child

_____Sex: Male ☐ Female ☐

Grade Level Student's Teacher

Does your child have any allergies to any foods, if so, which ones:_____

_____

Does your child have any allergies to any medications, if so, which ones:_____

_____

Does your child have any physical limitations? _____

_____

Does your child have any other medical conditions which staff should be aware of?_____

_____

Please state any other information you feel will help us work with your child_____

_____

In the event of an emergency I grant permission for emergency medical treatment to be given and I agree to pay all medical bills not covered by the insurance company listed below. I release the Hockinson School District from responsibility for any bills resulting from injuries incurred in these programs. I have listed information regarding allergies or other medical conditions about my child of which staff should be aware.

Name of Child's Physician_____ Phone Number _____

Address_____

Insurance Company_____

_____

Parent/Guardian Signature Emergency Phone Number

***If you child needs prescribed medication, please fill out Authorization for Administration of Medication at Clark County School form.** I understand the district shall incur no liability as a result of any injury arising from the self-administration of medication by the student, and parents/guardians shall indemnify and hold harmless the district, and its employees or agents against any claim arising out of the self0administration of medication by the student.