

Medical Information

Student's Name _____

Doctor _____ Telephone _____

Hospital Insurance Co. _____ Policy No. _____

Does your child take any prescribed medications? If so, please list. _____

Does your child have a medical condition about which we should know? If so, please explain.

Permission for Medical Treatment

I, _____, (Parent/Guardian), the undersigned, declare my child _____ is in good physical health and may participate in any/all activities as planned or directed by St. John's Episcopal School. In an emergency, St. John's Episcopal School, its agents, and/or affiliates have my permission to obtain emergency treatment at a local hospital including blood transfusions if attending physician deems such treatments necessary.

I give permission. _____ (initial) I do not give permission. _____ (initial)

Permission for Use of Photos/Videos

St. John's Episcopal School and all affiliates thereof have my permission to use any photographs, art objects, or video tapings of my child for future use in any/all St. John's Episcopal School publications and promotional materials.

I give permission. _____ (initial) I do not give permission. _____ (initial)

Release of Liability

I, _____, the undersigned, do hereby release St. John's Episcopal School, its agents, affiliates, and any/all related personnel from any/all liability in the event of an accident or injury to my child, _____.

Printed Name of Parent/Guardian _____

Signature of Parent/Guardian _____ **Date** _____