

**WINSTON-SALEM/ FORSYTH COUNTY SCHOOLS DEPARTMENT OF ARTS EDUCATION
ALL-COUNTY MEDICAL RELEASE FORM**

All information provided will be on file with the clinic chair and remain confidential.

Student's Name _____
(last) (first) (middle)

Student's Address _____

City _____ State _____ Zip _____

SCHOOL NAME OF THE PARTICIPATING STUDENT _____

MUSIC DIRECTOR'S NAME _____

Student's Date of Birth _____ Age _____

Father's Name _____ Home Phone _____ Cell Phone _____

Mother's Name _____ Home Phone _____ Cell Phone _____

If parents are not legal guardians, guardian's name and address:

INSURANCE / EMERGENCY INFORMATION

Under whose insurance is the student covered? (please circle)

Father Mother Both School

Name of Insurance Company _____ Policy Number _____

Agent's Name _____ Agent's Address _____

List two people to notify of in an emergency if parent/guardian cannot be reached:

Name _____ Phone _____ Relation to Student _____

Name _____ Phone _____ Relation to Student _____

Please provide the following information or circle all that apply:

ALLERGIES

Food _____

Date of last Tetanus Shot _____

Medication: Penicillin _____ Sulfa _____

Other _____

Conditions (Circle all that apply)

| | | | |
|--------------------|-------------------------|---------------------|--------------------|
| Epilepsy | Rheumatic Fever | Asthma | Dizziness/Fainting |
| Eyes | Ears | Nose | Throat |
| Hay Fever | Diabetes | Stomach | Heart Palpitation |
| Jaundice/Hepatitis | Kidney/Urinary Problems | Depression/Behavior | Knees/Legs/Walking |

Other Conditions / Special Notes Concerning Conditions:

Does student take medication on a regular basis? Y or N If yes, list medication and dosage _____

Family Physician _____ Office Address _____

Office Phone _____ Home Phone _____

As parent/guardian of the named child/student, I hereby give permission to the supervising teacher or WS/FCS representative to request usual and customary medical/safety services for my son/daughter if needed at this event. It is understood that I will be responsible for all costs not covered by my insurance.

Signature of Parent/Guardian _____ Date _____

This form MUST be signed and returned to the music director who will leave the form on file with the clinic chairperson.