

Madison County Schools
Extracurricular Participation/Out-of-County/Overnight Activity Medical Release
Form/ Waiver

Student:

| | | | | |
|------|---------------|----------------|-------------|----------|
| Name | Date of Birth | Street Address | City, State | Zip Code |
|------|---------------|----------------|-------------|----------|

Parent:

| | | | |
|------|------------|------------|------------|
| Name | Home Phone | Work Phone | Cell Phone |
|------|------------|------------|------------|

Emergency Contact:

| | | | | |
|------|--------------|------------|------------|------------|
| Name | Relationship | Home Phone | Work Phone | Cell Phone |
|------|--------------|------------|------------|------------|

Physician:

| | | | | |
|------|----------------|-------------|----------|-------|
| Name | Street Address | City, State | Zip Code | Phone |
|------|----------------|-------------|----------|-------|

Insurance Information: Not Covered

| | | |
|----------|------------------|---------|
| Provider | Contract or ID # | Group # |
|----------|------------------|---------|

I waive any claims or cause of action against the Madison County School System and employees of the system which may arise by reason of injuries to my child because of such participation and agree that said School District and employees are released and forever acquitted from any and all claims of liability to me or my child.

A completed and signed *School Medication Prescriber/Parent Authorization Form* is required for each medication, prescription or over-the-counter, to be administered while your child is participating in such events and/or activities.

If your child has a *School Health Management Plan* for a chronic health condition on file with his/her School Nurse, a copy of that plan should accompany this form and be in the possession of the Madison County Schools employee serving as the event/activity sponsor or coach.

GENERAL STUDENT HEALTH INFORMATION:

1. Will your child require medication while participating in this event or activity? YES NO
2. Does your child have allergies? YES NO If yes, please list: _____
3. Does your child require medication to treat a severe allergic reaction? YES NO
If yes, please list all possible triggers related to your child's severe allergy: _____
4. Does your child have asthma? YES NO Does he/she use an inhaler? : at school at home or both
5. Does your child have diabetes? NO YES (If "yes", Type I or Type II?)
6. Date of your child's last Tetanus Booster: _____
7. Is there any other health history that may assist the event/activity sponsor or coach in the event your child becomes ill or is injured?

Authorization to Share Personally Identifiable and Medical Information:

I hereby authorize the Madison County Schools representative serving as my child's activity sponsor, coach, or School Nurse, to release to the Team Physician, Athletic Trainer or other medical personnel, personally identifiable and medical information pertinent to the care of my child during his/her participation in a school-sponsored event or activity.

Signature of Parent/Custodian

Date

Authorization to Treat/Administer Medication:

I hereby authorize medical or surgical treatment of my child in the event of an emergency. I give permission for decisions to be made by the Madison County Schools representative serving as my child's activity sponsor or coach. NOTE: Your signature on this form acknowledges your acceptance of financial responsibility for any medical or dental care your child requires.

_____ has my permission and consent to participate in extra curricular activities.

Student's Name

Signature of Parent/Guardian

Date

Signature of Notary

Date

State

County

Date Commission Expires