

Student Name: _____

Allergies: _____

Medical Conditions: _____

Remarks: _____

Medical Release:

In case of accident or serious illness, I request that the school contact me. If the school is unable to reach me, I hereby authorize the school to call the physician listed below and to follow his instructions. If it is impossible to contact this physician, the school may make whatever arrangements are necessary.

Signature of Parent/Guardian

Date

Physician Name

Phone

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