

Winterguard Medical Release Form

Student Information

Name: _____ School: _____

DOB: _____ Grade: _____ Cell Number: _____

Parent Information

Mother/Guardian Name: _____

Address: (if different than above) _____

City, State, Zip _____ Cell Number : _____ Other: _____

Email Address: _____

Father/Guardian Name: _____

Address: (if different than above) _____

City, State, Zip _____ Cell Number : _____ Other: _____

Email Address: _____

Emergency/Other Contacts

Name: _____ Relation to Student: _____

Cell Number: _____ Other: _____

Name: _____ Relation to Student: _____

Cell Number: _____ Other _____

In case of emergency, contact the following first: _____ Mother/Guardian _____ Father/Guardian

Medical Information

Does your child have any food/drug allergies: _____ Yes _____ No (If yes, please explain below.)



Chronic Health Problems/Concerns:

Current Medications:

Please list any medication/supplies that your child should have with them at every event (EpiPen, diabetic supplies, inhaler, etc.)

Other Comments:

I hereby give my permission for my child _____ to be administered or assisted in the self-administration of the medication listed below by authorized persons in the treatment of a non-emergency medical nature. This includes both at school and off-campus activities. This would include administering medication such as: (Check all that apply.)

Parent Signature: _____ Date: _____

- Acetaminophen (Tylenol)
- Ibuprofen (Advil)
- Midol/Pamprin
- Benadryl(For Stings, etc)
- Pepto, Tums, etc. (for nausea)
- Neosporin

Physician Name: _____ Phone Number: _____

Insurance Company: _____ Policy Holder: _____
Policy Number: _____ Insurance Phone _____

I certify that the above history is correct as far as I know. I further certify that in the event I cannot be reached in an emergency, I hereby give permission to the Physician selected by the directors to perform such treatment as he may deem necessary to preserve the health of my child.

Parent Signature: _____ Date: _____