NOTE: THIS FORM MUST BE COMPLETED, SIGNED, AND KEPT BY THE ADVISOR THROUGHOUT THE CONVENTION

MEDICAL PERMISSION FORM

(Please print or type)

Name: _____ Age: _____ Sex: _____
Last First Middle

Address: _____
Number/Street City State Zip

Parent's daytime phone(s): (_____) _____ (_____) _____

Name and phone number of person to be contacted in case of emergency (If parents cannot be reached):

_____ Phone: (_____) _____

School I attend: _____ School Phone: (_____) _____

School Principal: _____ Home Phone: (_____) _____

Physician's Name: _____ Phone Number: (_____) _____

BRIEF MEDICAL HISTORY

Special Health Concerns (allergies, etc.): _____

Current Medications: _____ Dosage per day: _____

Asthma: ☐ yes ☐ no Medication: _____

Diabetes: ☐ yes ☐ no Medication: _____

Epilepsy: ☐ yes ☐ no Medication: _____

Should student be restricted from any type of activity? ☐ yes ☐ no

If yes, please explain: _____

Are there any prescription or non-prescription drugs that should NOT be administered? ☐ yes ☐ no

Allergic to any medication? ☐ yes ☐ no If yes, list _____

A licensed health care provider may provide my child with ☐ Tylenol ☐ Advil ☐ Either ☐ Neither

NOTE: If you are taking medication regularly, please bring a supply in a labeled container.

I, the parent/legal guardian of _____ (my child), authorize the South Dakota Student Council Association to obtain medical care for my child in the event such care is necessary. I understand that, if possible, I will be contacted in the event my child requires medical attention. I grant to a licensed health care provider or accredited hospital permission to perform any medical and/or surgical procedures that are essential for the treatment of my child and agree to be responsible for payment for such care. I release SDSCA, its Board, and staff from any damages, liability, or loss resulting from their securing in good faith medical care for my child.

Parent or Guardian Signature: _____ Date: _____