Trinity Klein Lutheran Church & School
5201 Spring Cypress Road, Spring, TX 77379
(281) 376-5773

Medical and Liability Release Form
RELEASE OF ALL CLAIMS

FOR OFFICE USE Staff Initials ________
Valid through August 31, 20___
(This form must be renewed each August)

This form must be completed and signed by a parent or guardian. The annual medical and liability release form is designed to provide information in the event of an emergency, permission to seek medical treatment, and parental consent of participation. Please complete the required information legibly.

Student's Name _________________________________ (Last, First, MI) Age (as of 9/1/2018) ______
Date of Birth ________________ (mm/dd/yyyy) Anticipated High School Graduation Year _________
Home Address __________________________________ City _________________ Zip ____________
Home Phone (_______) _______ - ___________
Mother's Name ___________________________ Father's Name _______________________________
Work Phone (_______) _______ - ___________ Work Phone (_______) _______ - ___________
Cell Phone (_______) _______ - ___________ Cell Phone (_______) _______ - ___________

Emergency Contacts Please list information for two people who could be contacted in case of emergency if the parent/guardian cannot be reached (relatives/close friends). These people may provide information regarding where the parent/guardian might be reached, or they might be asked to give advice/permission for medical care. **Please notify individuals that their names have been given for this purpose.**

1. Name _______________________________________ Relation to Student: ___________________
Address ____________________________ City _________________ State ______ Zip ____________
Phone (_______) _______ - ___________

2. Name _______________________________________ Relation to Student: ___________________
Address ____________________________ City _________________ State ______ Zip ____________
Phone (_______) _______ - ___________

Is the student covered by family medical/hospital insurance? ______Yes ______No

Insurance Company ____________________________________ Policy Number _________________
Name of Subscriber ____________________________________

Photocopy of front and back of health insurance card must submitted with this form.

Name of Primary Physician ___________________________ Phone (_______) _______ - ___________
Address ____________________________ City _________________ State ______ Zip ____________

General Health Information and History

Has/does the student	Yes	No
1. Had any recent injury, illness, or infectious disease?	____	____
2. Have any chronic or recurring illness or condition?	____	____
3. Ever been hospitalized?	____	____
4. Ever had surgery?	____	____
5. Have frequent headaches?	____	____
6. Ever had a head injury?	____	____
7. Ever been knocked unconscious?	____	____
8. Wear glasses or contact?	____	____
9. Ever been dizzy or passed out during or after exercise?	____	____
10. Ever had frequent ear infections?	____	____
11. Ever had chest pain during or after exercise?	____	____
12. Ever had seizures?	____	____
13. Ever had high blood pressure?	____	____
14. Ever been diagnosed with a heart murmur?	____	____
15. Ever had back problems?	____	____
16. Ever had problems with joints (i.e. knees, ankles)?	____	____
17. Use an orthodontic appliance?	____	____
18. Have diabetes?	____	____
19. Have asthma?	____	____
20. Had mononucleosis in the past 12 months?	____	____
21. Have frequent stomach aches or indigestion?	____	____
22. Have problems with sleep walking?	____	____
23. Ever had an eating disorder?	____	____
24. Have any allergies to medications?	____	____
25. Have any food allergies?	____	____
26. Have any other allergies (i.e. insect bites, Hay fever, animal dander, etc.)?	____	____

Please explain any "yes" answers, noting the number of question:
____
____
____

Date of Last Tetanus Immunization _________________ (mm/dd/yyyy)

Use this space to provide any additional information about the student's behavior and physical, emotional, or health concerns about which leaders should be aware: ____
____
____
____

Medications:
____ My child takes NO medications on a routine basis
____ My child may be given pain relievers (i.e. Advil, aspirin, etc.) as needed

____ My child takes medications as follows:
Med #1 _________________________________ Dosage________________ Specific time taken___________________________
Reason for taking ____

Med #2 _________________________________ Dosage________________ Specific time taken___________________________
Reason for taking ____

Med #3 _________________________________ Dosage________________ Specific time taken___________________________
Reason for taking ____

MEDICAL RELEASE AUTHORIZATION BY PARENT(S)/GAURDIAN(S)
After failed attempts to contact us (Me), we (I) authorize the responsible adult representing Trinity Klein Lutheran Church, in whose care the minor has been entrusted, to consent to any x-ray examination, anesthetic, medical, surgical, or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization. Should it be necessary for our (my) child to return home due to medical reasons or otherwise, the undersigned shall assume all transportation costs. The undersigned does also herby give permission for our (my) child to ride in any vehicle designated by the adult in whose care the minor has been entrusted while attending and participating in activities sponsored by Trinity Klein Lutheran Church.

[The following signatures must be hand written.]

PARENT NAME (PRINT)____

SIGNATURE ____ DATE ____________________

PARENT NAME (PRINT)____

SIGNATURE ____ DATE ____________________