Print Form

Parents: Please fill this form out carefully and completely. This is theMedical Form required by GISD and must be completed before any child participates in any GISD extra-curricular function.

GISD SPECIAL SITUATIONS STUDENT MEDICAL INFORMATION FOR TRIPS

Event: BAND School: ______________ Today's Date ______________________

Student Name: ____ Birthdate: _________________________

Home Phone: ______________________ Social Security #: ______________________Gender: male female

Current Address: ____
Street/P.O.Box City State Zip

Father's Name: ___________________________Home Phone:_____________Work:_______________Cell_________

Mother's Name:___________________________ Home Phone: ____________Work: ______________Cell_________

Emergency Contact:________________________________Phones: ____

Health Insurance Company: _________________________Member Name:____________________________________

Member I.D. # ______________________ Group #_______________________Policy #: _________________________

Please list your preferred provider (Clinic, Doctor, HMO, etc.) List the provider's name, address, and phone

number. ____

____

Please indicate medical alerts such as allergies, contact lenses, chronic illness such as Asthma, Diabetes, etc.

____

STUDENT HEALTH HISTORY AND RECORD

NAME: ____________________________________ AGE: ________ GRADE:_____ DATE:_____________________

ADDRESS: ____ PHONE: _________________________________

HEALTH HISTORY

Please list any allergies to medication, food, or other allergens, and type or reaction:__________________________

____

Does student have any chronic health conditions? Yes __ No ___ Date: ________Please List__________________

____

Has student ever been hospitalized? Yes ___ No ___ Date: ____________Reason: ___________________________

Does student take any medications on a regular basis? Yes ___ No ___ Please list medication, dose, and times

taken,and reason: ____

Are you concerned about any health concerns for the student at this time? Yes _____ No _____

What are they? ____

Parent Signature: ____ Date ______________________________

MEDICATION PERMISSION

I give my permission for GISD staff, or the nurse on duty, to administer the following medications while on any band trip. I understand that no other medications will be made available or administered to my child by GISD staff on any band trip. All medications will be brought in original containers and all prescription medications will be brought in a pharmacist labeled bottle.

Name of medication	Strength of medication	Dose	Frequency	Reason for medication

Parent Signature:______________________________________ Date: ____________________

IMPORTANT INSURANCE NOTICE

Catastrophic Health Insurance is available through the Georgetown ISD. This is especially recommended for any students involved in high-risk activities like athletics or gymnastics. It is also recommended that students have personal health insurance.

RELEASEES AND WAIVERS

Signify your approval by writing your initials in the space before the statement(s) and signing below.

_______1. In the event of an injury or illness to the above named student, I hereby authorize a representative of GISD to secure emergency medical treatment for the above named student from any healthcare provider.

_______2. I understand that I will be financially responsible either with personal health insurance or other means, for medical treatment needed by my child.

_______3. I certify that the information provided on this form is true and correct to the best of my knowledge.

_______4. I hereby authorize the release of medical records and information as well as medical insurance information to the healthcare providers as needed for the treatment of injuries and illness to my child.

_______5. I hereby authorize GISD staff, or nurse on duty, to administer the medications listed on this page of the document. I understand that the GISD will not provide medications for my child on this trip. I release from liability GISD, its staff, and nurses for any medication reactions or medication allergy that my child experiences.

_______6. I hereby agree to bring this information up to date, as the need arises, before any band trip that might require medical attention.

_______7. I hereby give my permission for GISD to use photographs of my student for publication in newspapers, web pages, and/or other media.

Parent's Signature____ Date: ______________

Proof of I.D ____Expiration Date: ______________

GEORGETOWN EAGLES – ATHLETE INFORMATION **2009-2010 SCHOOL YEAR**

Sport(s) ______________________________Today's Date ______________Gender: male female

Name:______________________________ Birthdate____________ Home Telephone__________________

Grade (2009-2010):__________ School: HS 9th Grade Center Benold Tippit Forbes Student ID#______________

Current Address:____
Street/P.O. Box City State Zip

Father's name:______________________________ Daytime Phone:________________ Cell Phone:______________

Mother's name:______________________________ Daytime Phone:________________ Cell Phone:______________

Parent/Guardian's Email: ____

Health Insurance Company Name:______________________________Member Name:______________________________

Member I.D. #________________________ Group #____________________ Policy #______________________

If your insurance coverage requires (or if you prefer) a specific provider (clinic, doctor, HMO, etc.), please list the provider's name, address and phone number

____

Please indicate medical alerts such as allergies, contact lenses, asthma, etc. ______________________________

IMPORTANT INSURANCE NOTICES

Catastrophic Health Insurance:
All students participating in athletics (including try-outs) in the Georgetown Independent School District (GISD) must purchase a catastrophic insurance policy arranged by the school district. Generally, this blanket policy pays benefits for medical expenses which **exceed** $25,000.00 per occurrence (see plan documents for details). The cost for this insurance is $10.00 for a student who participates in football and $5.00 for a student who participates in any sport other than football.

Primary Health Insurance:
It is **recommended** that all students who are participating in athletics have personal health insurance or purchase the GISD voluntary health insurance plan. IF A STUDENT DOES NOT HAVE VALID PERSONAL INSURANCE COVERAGE, THE GISD VOLUNTARY POLICY IS HIGHLY RECOMMENDED. For additional information please contact the Athletic Training Department. The Catastrophic Insurance is different from the GISD Voluntary Policy.

RELEASES AND WAIVERS

Signify your approval by writing your initials in the space before the statement(s) and signing below:

_____ 1. IN THE EVENT OF AN INJURY OR ILLNESS TO THE ABOVE-NAMED STUDENT, I HEREBY AUTHORIZE A REPRESENTATIVE OF GISD TO SECURE EMERGENCY MEDICAL TREATMENT FOR THE ABOVE-NAMED STUDENT FROM ANY HEALTHCARE PROVIDER.

_____ 2. I UNDERSTAND THAT, IN ADDITION TO ANY PERSONAL HEALTH INSURANCE COVERAGE ON MY CHILD, I MUST PURCHASE CATASTROPHIC MEDICAL INSURANCE ARRANGED BY GISD. IN ADDITION, I UNDERSTAND THAT I WILL BE FINANCIALY RESPONSIBLE, EITHER WITH PERSONAL HEALTH INSURANCE OR OTHER MEANS, FOR MEDICAL TREATMENT NEEDED BY MY CHILD. I AUTHORIZE GISD ATHLETIC TRAINER(S) TO FILE AN ELECTRONIC CLAIM FORM FOR THE CATASTROPHIC INSURANCE IF THE SITUATION ARISES.

_____ 3. I CERTIFY THAT THE INFORMATION PROVIDED ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

_____ 4. I HEREBEY AUTHORIZE THE RELEASE OF MEDICAL RECORDS AND INFORMATION AS WELL AS MEDICAL INSURANCE INFORMATION TO THE GISD ATHLETIC TRAINER AND HEALTHCARE PROVIDERS AS NEEDED FOR TREATMENT OF INJURIES AND ILLNESS TO MY CHILD.

_____ 5. I AUTHORIZE GISD ATHLETIC TRAINER (S) TO ADMINISTER NON-PRESCRIPTION MEDICATION TO MY CHILD.

Parent's/Guardian's Signature______________________________ Date__________________

Athlete's Grade:_______

NON-PRESCRIPTION MEDICATION ACKNOWLEDGEMENT/ RELEASE FORM

The following non-prescription medications can be made available for all athletes as deemed necessary by the athletic trainer following the guidelines and / or directions of a team physician:

Cough drops, antihistamine tablets, non-aspirin pain relief (acetaminophen, ibuprofen),

anti-acid tablets, decongestant tablets, anti-diarrhea tablets,

electrolyte replacement tablets, electrolyte drinks (Gatorade, Powerade),

anti-fungal crème, hydrocortizone crème, antibiotic ointment, hydrogen peroxide

My child may <u>not</u> have any of the above medications that I have circled.

____

Parent's/ Guardian's signature