STUDENT HEALTH HISTORY FOR PARTICIPATION:

Student Name:____ Birthdate:____________________
Last First Middle

1. To the best of your knowledge, has your child been exposed to a communicable disease within the past 21 days?
   _________ Yes _________ No

2. Does your child have any of the following health problems? Please answer **Yes** or **No**.
   a. Operations or serious injuries in the past two years
   b. Chronic or recurring illness
   c. Recent broken bones
   d. Asthma
   e. Heart disease
   f. Hay fever
   g. Fainting spells
   h. Hernia (rupture)
   i. Seizures (Epilepsy)
   j. Diabetes

   Other physical conditions or diseases : (Dates)

3. Date of most recent **Tetanus** shot

4. Does your child have any drug or other allergies? (Insect bites or stings, penicillin, plants or pollens, foods, etc.)

5. Medications child takes (Type of Medication, reason, dosage and frequency, name of prescribing physician):

6. If you have any concerns regarding your child's physical ability to participate in this activity, it is advisable for your child to have a physical examination.

RELEASE OF LIABILITY AND CONSENT TO EMERGENCY MEDICAL TREATMENT

The above health history is correct so far as I know, and I consent and grant my permission for my son/daughter/ward to engage in all described activities. Except as noted by me, my child is physically fit to participate.
I (we) the undersigned parent, parents, or legal guardian of ____, a minor, do hereby consent that he/she be permitted to fully participate in the fieldtrip, excursion or any form of transportation and should the need arise, do hereby authorize and consent to any x-ray, examination, anesthetic, medical or surgical diagnosis and treatment rendered under the general or special supervision of any member of the medical staff or emergency room staff. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required and is given to provide authority and power to render any care, which the medical provider in the exercise of his/her best judgment may deem advisable. It is understood that an effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatments will not be withheld if the undersigned cannot be reached. I will not hold liable the **provider,** Becca Yuré, M.Ed., BCBA, for medical aid rendered and will reimburse **this provider** for all medical or other expense incurred in the care of my son/daughter/ward.

In order that my son/daughter/ward may receive the necessary medical treatment in the event of an injury or illness, I hereby hold the **provider,** __Becca Yuré, M.Ed., BCBA**,** harmless in the exercise of this authority.

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Signature of Parent or Guardian **Date**