STUDENT MEDICAL RELEASE FORM

Each student must complete and return this form with their registration form & check

Student Name: _____Social Security Number: _____

Male: _____ Female: _____ Height: _____ ft. _____in. Weight: _____lbs.

School: _____

Yes	No	
☐	☐	Does the state of your health require that special medical arrangements be made? IF YOU ARE NOT TOTALLY MOBILE OR INDEPENDENT WITHOUT ASSISTANCE OR SPECIAL MEDICATION CHECK "YES" FOR THIS QUESTION. If yes, please specify: _____
☐	☐	Do you take medication with any regularity and /or during an emergency? If yes, please specify: _____

Do you or have you had in the past any of the following:

☐	☐	Any orthopedic problems? (Acute or chronic sprains, casts)
☐	☐	Cerebral palsy or other physically debilitating ailment?
☐	☐	Any condition causing difficulty in walking or mobility or requiring the use of a wheelchair, crutches, or cane in walking distances of over ½ mile?
☐	☐	Hypoglycemia or diabetes? Please specify: _____
☐	☐	Any allergies to food or drugs? Please specify: _____
☐	☐	Any long-term treatment or evaluation testing by a physician for a physical condition? Please specify: _____
☐	☐	Epilepsy? (Controlled or not)
☐	☐	Any gastro-intestinal disorders? (e.g. nervous stomach, ulcer, colitis)
☐	☐	Hearing impaired, deafness, legally blind. Please specify: _____
☐	☐	Are you currently pregnant?
☐	☐	Are you being or have you been treated for nervous disorders? Please specify: _____
☐	☐	Any surgical procedures in the last 3 months?

If the answer to any of the questions above is "yes", please indicate on the reverse when the condition began (date), the nature of the problem and any remaining effects. *(Example: for orthopedic problems: Happened in the summer of 2001; nature of problems-weak knees; remaining effect-slight pain during extensive walking.)*

If, in the opinion of Close Up staff, this student is in need of medical/hospital consultation or treatment, we hereby authorize such consultation or treatment as necessary.

Signature of Parent or Guardian: _____ Date _____

Name of Parent or Guardian: _____
Address: _____
City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____
Health Insurance Provider:_____
Policy Number:_____
Secondary Contact: _____ Phone: _____