Henderson County High School
Choral Department

MEDICAL PERMIT

I hereby consent for a qualified physician or surgeon to examine, diagnose, prescribe and perform treatment, including surgery, which is deemed advisable for the welfare of:

STUDENT'S FULL NAME_____

Please list any medical concerns and medications the student currently takes: _____
_____
_____

List any known allergies:
Medications _____
Food _____
Environmental _____
Date of Last Tetanus Inoculation:_____

INSURANCE COMPANY_____ POLICY NUMBER _____
SUBSCRIBER NUMBER_____ GROUP NUMBER _____
PERSONAL PHYSICIAN_____ PHYSICIAN'S PHONE _____

If an operative procedure is recommended, I hereby consent to the administration of any anesthetic, general, local, or both by a qualified anesthesiologist. If a blood transfusion is necessary, I consent to this procedure. I understand that no one connected with Henderson County High School or Henderson County Public Schools assumes liability for any injury incurred by the participant. I agree to pay all costs incurred by the participant(s) for the hospital bills, physician fees, and ambulance fee. I understand that I will be contacted by someone in authority at the time my child is admitted to the hospital and/or treated by a physician.

SELF MEDICATION ADMINISTRATION PARENT/GUARDIAN STATEMENT

I, the undersigned Parent(s)/Guardian(s) of (print) _____ give consent for ***my student to self-administer** the above medication(s). I understand the Henderson County Board of Education Medication Policies & Procedures (09.2241) are readily available for me to read. I hereby agree to release and hold the school staff free and harmless for any claims, demands, or suits for damages from any injury or complication that may result from such treatment. I have read this consent and understand all its terms. I sign it voluntarily and with full knowledge of its significance. I understand that self-administered medication is not provided by or monitored by the School Nurse or school staff.

Please note, per policy, no student may carry or self-administer a controlled substance.

X _____ ____ / ____ / ____
(PARENT/GUARDIAN SIGNATURE) *Date*

RELATIONSHIP TO STUDENT_____

Parent Home: _____ Parent Work: _____
Parent Cell 1: _____ Parent Cell 2: _____

Additional Emergency Contact Name: _____
Additional Emergency Contact Number: _____