Credo Academy
Medical History/Release Form

Place Current Photo Here

Student's Name (First, M.I. Last): _____

Date of Birth: _____ Age: _____

Home Address: _____ City: _____ Zip: _____

Persons to contact in case of an emergency: List parent(s) and best phone numbers first:

Full Name	Relationship to Student	Best Phone Number

Check ANY of the following that the student has or has had:

___ Allergies/Hay Fever
___ Asthma
___ Allergies to Medicines, specify _____
___ Diabetes
___ Dizziness
___ Ear Infections
___ Emotional Disorders
___ Epilepsy
___ Eyeglasses/Contacts
___ Fainting Spells/Convulsions
___ Headaches/Migraines
___ Hearing Impairment
___ Heart Trouble
___ HIV
___ Lung Disease
___ Nosebleeds
___ Sinus Trouble
___ Special Diet
___ Other, specify _____

Does the student have any other conditions or allergies not listed above that we should know about?

_____

Does the student take any prescription medication? _____
Primary Physician _____ Phone Number _____
Medical Insurance Carrier _____ Policy/Group # _____
Medical Share Program _____

I, the parent/guardian of the above-named student, give permission to Credo Academy to seek emergency medical/ surgical treatment as necessary in my absence.
I understand that every attempt will be made to contact me or the emergency contact(s) above before taking action, if at all possible. I hereby waive and release Credo Academy from any liability for any injury or illness incurred while attending Credo Academy classes or functions. I will be financially responsible for any medical attention needed for this student and will contact Credo Academy if there are any changes to the information provided on this form.

Father's Signature _____ Mother's Signature _____ Date _____

***This form is for emergency use only.**
If your student's teacher(s) need to know about any of the above information, it is your responsibility to inform them.