

## Medical Information Form

Please complete and mail to: SEEK, P.O. Box 937, Crawfordville, FL 32326

Student Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_  
(Month) (Day) (Year)

Allergies and Treatment Required: \_\_\_\_\_  
\_\_\_\_\_

Special Medical Conditions or Needs: \_\_\_\_\_  
\_\_\_\_\_

Medications: \_\_\_\_\_

Family Physician

Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

You may give my/our child the following over-the-counter medications if needed or requested:  
(Check all that apply)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Aspirin                  | <input type="checkbox"/> Ibuprofen (Motrin) | <input type="checkbox"/> Acetaminophen (Tylenol) |
| <input type="checkbox"/> Antibiotic Ointment      | <input type="checkbox"/> Benadryl Cream     | <input type="checkbox"/> Cortisone 10 Cream      |
| <input type="checkbox"/> Anti-diarrheal (Imodium) | <input type="checkbox"/> Pepto-Bismol       | <input type="checkbox"/> Antacid                 |
| <input type="checkbox"/> Antihistamine            | <input type="checkbox"/> Decongestant       | <input type="checkbox"/> Sore Throat Lozenge     |

I/we authorize and consent to any X-ray, examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care to such minor under the general or special supervision, and on the advice of a licensed physician, surgeon, anesthesiologist, dentist, or other qualified medical personnel acting under their supervision. In addition, I/we authorize SEEK or their authorized adult to transport my child for medical attention. I/we agree to pay for any such expenses, have health insurance coverage with \_\_\_\_\_, and will file any insurance payment or reimbursement forms required.

*(Please make and attach xeroxed copies of both sides of your health insurance card. Thank you.)*

I/we voluntarily agree to release, waive, discharge, hold harmless, defend and indemnify SEEK and its agents from any and all claims, actions or losses for bodily injury, property damage, wrongful death, loss of service, or otherwise which may arise from participating in SEEK.

I/we, the undersigned, are the parent(s) or legal guardian of \_\_\_\_\_.

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Date: \_\_\_\_\_