



**St. Margaret's Episcopal School**  
 31641 La Novia,  
 San Juan Capistrano, CA 92675  
**Phone (949) 661-0108 (ext 203) Fax (949) 661-5497**

**Division:**  
**Grade:**  
**Last Name:**  
**First Name**

## 2012-2013 Medical Release

**Student Full Legal Name:** \_\_\_\_\_ **Home Phone:** \_\_\_\_\_

**Preferred Name:** \_\_\_\_\_ **Gender:** \_\_\_\_\_ **Birth Date:** \_\_\_\_\_ **Cell Phone:** \_\_\_\_\_

**Street Address:** \_\_\_\_\_ **City:** \_\_\_\_\_ **St:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

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

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_ Insurance Phone: (\_\_\_\_) \_\_\_\_\_

Insurance Street Address: \_\_\_\_\_ City: \_\_\_\_\_ St: \_\_\_\_\_ Zip: \_\_\_\_\_

**Medical History (check when appropriate)**

Date of last tetanus booster: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ (Due every 5-10 years)

**Will your child be taking**  Yes  No **If yes, list medication, dosage, and when taken:** \_\_\_\_\_  
**prescribed medication at school?** \_\_\_\_\_

**Special health problems**  Yes  No **If yes, diagnosis:** \_\_\_\_\_

**Recent surgery/injury**  Yes  No **If yes, list with dates:** \_\_\_\_\_

**Serious allergies/foods/meds**  Yes  No **Describe:** \_\_\_\_\_  
**Treatment:** \_\_\_\_\_

**Bee sting allergic reaction**  Yes  No **# of times stung:** \_\_\_\_\_ **Reaction:** \_\_\_\_\_  
**Treatment:** \_\_\_\_\_

**Seizures**  Yes  No **Describe:** \_\_\_\_\_  
**Treatment:** \_\_\_\_\_

**Asthma**  Yes  No **Treatment:** \_\_\_\_\_  
 Yes  No **Inhaler will be provided to Nurse's Office (must be accompanied by physician order)**

**Diabetes**  Yes  No **Treatment:** \_\_\_\_\_

**History of migraine**  Yes  No **Treatment:** \_\_\_\_\_

**Heart condition**  Yes  No **Diagnosis:** \_\_\_\_\_

**Check Consent for:**  Tylenol  Advil  Sudafed  Benadryl  Pepto Bismol (administered by nurse)

**All medication must be in the properly labeled pharmaceutical container. Requests for the administration of prescription medication at school or on a school-related function must be accompanied by the physician's order.**

Emergency Contact 1: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact 2: \_\_\_\_\_ Phone: \_\_\_\_\_

Emergency Contact 3: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_