



The Master's Study

Student Medical Information with Medicinal Release

(Please print one page per student)

Student Information	Student's Name _____		Date of Birth _____	
	Parent Name(s) _____			
	Mother's Urgent Contact Info		Father's Urgent Contact Info	
	Home Phone _____		Work Phone _____	
	<input type="checkbox"/> Leave Voice Mail / Message		<input type="checkbox"/> Leave Voice Mail / Message	
	Cell _____		Cell _____	
<input type="checkbox"/> Text Messaging Enabled		<input type="checkbox"/> Text Messaging Enabled		

Important Health Information	Student Allergies	<input type="checkbox"/> Peanuts <input type="checkbox"/> tree nuts <input type="checkbox"/> Shellfish <input type="checkbox"/> Dairy <input type="checkbox"/> Gluten <input type="checkbox"/> Other Foods <i>(Please list)</i>	<input type="checkbox"/> Bee Stings <input type="checkbox"/> Poison Ivy <input type="checkbox"/> Laytex / Rubber <input type="checkbox"/> Other Environmental <i>(Please List)</i> <input type="checkbox"/> Medication <i>(Please List)</i>	Does the Student carry an Epi Pen to address any allergy issues? <input type="checkbox"/> YES <input type="checkbox"/> NO
	Other Important Medical Information or Instructions:	Physician Name _____		Phone # _____
		Hospital Preference _____		

Medicinal Release

The undersigned hereby authorize The Master's Study to administer the following over-the-counter medicines as directed using the child's age and weight. *No administration will occur to a child under the age of 12 without verbal parental consent at the time of administration.*

YES NO Benadryl (*Diphenhydramine*)
 YES NO Tylenol (*Acetaminophen*)

YES NO Motrin (*Ibuprofen*)
 YES NO TUMS (*chewable anti-acid*)

Parent Name (print)

Parent Signature

Date

Parent Name (print)

Parent Signature

Date