

2010 NASC MEDICAL PERMISSION FORM

Advisers/state directors are required to keep a completed and signed medical form for each student in their charge at all times during the 2010 NASC Conference in Indianapolis, Indiana. Students, please give a copy to your conference adviser and keep one for you to place in your namebadge holder. NASSP/NASC will no longer keep copies of any student's medical form. Please have a copy of your insurance card or other proof of insurance with you.

(Please print or type)

Name: _____ Age: _____ Sex: _____
Last First Middle

Address: _____
Number & Street City State Zip

Date of Birth: _____ Social Security #: _____

Home phone: (_____) _____ Parent's name(s) _____

Parent's cell phone(s): (_____) _____ (_____) _____

Name and phone number of person to be contacted in case of emergency (if parents cannot be reached):

_____ Phone: (_____) _____

School I attend: _____ School phone: (_____) _____

School Address: _____
Number & Street City State Zip

School Principal: _____ Home phone: (_____) _____

Who is responsible for medical payments? Individual Insurance

If individual, please provide credit card information: VISA MasterCard

_____ Name on credit card Exp. Date Cardholder's Signature

Medical Insurance Company Name: _____ State: _____

Policy Number: _____ Name on Card: _____

Physician's Name: _____ Phone Number: (_____) _____

BRIEF MEDICAL HISTORY

Special Health Condition (list) Treatment/Medication and Dosage (if taken)

1. _____

2. _____

3. _____

Additional related information: _____

Should delegate be restricted from any type of activity? No Yes, Explain: _____

Are you allergic to any medication? No Yes If yes, list _____

A licensed health care provider may provide my child with Tylenol Advil Either Neither

NOTE: If you are taking medication regularly, you must bring a supply in its original, labeled container.

I, the parent or legal guardian of _____ (my child), authorize the National Association of Secondary School Principals to obtain medical care for my child in the event such care is necessary. I understand that, if possible, I will be contacted in the event my child requires medical attention. I grant to a licensed health care provider or accredited hospital permission to perform any medical and/or surgical procedures that are essential for the treatment of my child and agree to be responsible for payment for such care. I release NASSP, its employees, and agents from any damages, liability, or loss resulting from their securing in good faith medical care for my child.

Parent or Guardian Signature: _____ Date _____

ADVISERS, PLEASE HAVE A COPY TO KEEP WITH YOU AT ALL TIMES.