Educational Talent Search Program
Labette Community College
1227 Broadway Parsons, KS 67357
TEL: 620/820-1034 FAX: 620/421-4056

STUDENT HEALTH INFORMATION AND MEDICAL RELEASE FORM

PLEASE PRINT – This form must be filled out completely.

Participant Name _____ Date of Birth _____/_____/_____

Street Address _____ City, State _____ Zip _____

Area Code/Phone # _____ Gender: Male _____ Female _____

Emergency Contact

Name _____ Relationship _____

Street Address _____ City, State _____ Zip _____

Area Code/Phone # _____ Cell Phone _____ Work # _____

Emergency Contact

Name _____ Relationship _____

Street Address _____ City, State _____ Zip _____

Area Code/Phone # _____ Cell Phone _____ Work # _____

Permission for NON-Prescription Medications

By signing this statement, in the event it comes to attention of the STAFF of Talent Search that my child complains of illness, I hereby grant permission for NON-Prescription medications to be given to my child (i.e., Tylenol, Ibuprofen, cough drops, throat lounges).

Parent/Guardian Signature _____

Medical Permission for Participant and Staff

I hereby grant permission in the event I/my child is injured or becomes ill for medical care to be administered to me/my child and to use my/our personal insurance to cover such incidents. I hereby give permission to the physician selected to render medical treatment deemed necessary and appropriate by the physician.

Parent/Guardian Signature _____

Personal Insurance *Do you have medical/health insurance? YES NO* (Please circle one)

Insurance Company Name _____ Group # _____ Policy # _____

Medical Assistance Program _____ Card Number _____

Military Care Provider _____ ID Number _____

Physician Information

Physician Name _____ Health Care Facility _____

Street Address _____ City, State _____ Zip _____

Area Code/Phone # _____ Area Code/Fax # _____

Participant Name _____ Date of Birth _____/_____/_____

Participant/Staff Medical History Date of Last Tetanus Shot _____

This information is needed to better accommodate student participants and staff members. Please check if person named has any of the following conditions:

____ Allergies	_____Heart Conditions	_____ Seizures
____ Asthma	_____Migraine Headaches	_____ Other (please list) _____
____ Diabetes	_____Nose bleeds	_____

If yes, please explain: _____

_____

_____

Current Prescription Medications and Dosages: _____

_____

_____

Current NON-Prescription Medications: _____

_____

_____

Any Drug Allergies: _____

_____

_____

Release of Liability for Participants and Staff

I understand all reasonable safety precautions will be taken at all times by the Talent Search Program of Labette Community College and its agents during the events and activities. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I agree not to hold the Talent Search Program of Labette Community College and its staff liable for damages, losses, or injuries incurred by the subject of this form.

Signature of Participant _____ Date _____

Signature of Parent/Guardian _____ Date _____