Grade: (SY 16-17): _____

Sports: _____

Georgia Military College Prep School

MEDICAL RELEASE FORM

AUTHORIZATION TO ADMINISTER MEDICAL TREATMENT FROM GMC HEALTH SERVICES AND THE ATHLETIC TRAINER

School Year 2016-2017

I, _____, the parent, or guardian, or sponsor of _____,
(Print Name of Parent or Guardian or Sponsor's Name) (Print Name of Student)

a minor child who is a commuting student at Georgia Military College Prep School, living with parent/guardian/sponsor, do hereby give:

- My consent, that in the event all reasonable attempts by authorized school personnel to contact me have been unsuccessful, for the Principal of Georgia Military College Prep School, or his designated representative, to consent on my behalf to any x-ray examination, anesthetic, medical treatment, and hospital care of my minor child, as fully and effectively as if I were personally present.
- I authorize the above-mentioned officials of Georgia Military College to serve in "loco parentis" for the transfer of an authorization of administration of any treatment deemed necessary for the treatment of my minor child.
- I authorize the School Nurses of Georgia Military College to administer medications or treatments to my minor child according to the School Physician's Standing Orders/Nurse Protocol.
- I give permission for my child to receive medical attention from the Athletic Trainer as deemed appropriate by GMC Sports Medicine in the event of illness or injury. I will notify the Athletic Trainer of any injury that occurs within 48 hours of occurrence. This will ensure that all forms are completed in a timely manner.

I will be responsible for any medical or hospital fees or costs associated with the illness or treatment of this minor.

This authorization is granted pursuant to the provision of O.C.G.A. 31-9-2 (2) (4) of the Georgia Medical Consent Law.

Name of Student (Please Print): _____ **Date of Birth**: _____
First MI Last

Signature of Parent, Guardian/Sponsor : _____ **Date**: _____

Insurance Information: Company: _____ Company Phone #: _____ Name of Insured: _____

Allergies: _____ **Medical Conditions:** _____ **Medications:** _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

PARENT/GUARDIAN TO NOTIFY IN AN EMERGENCY SITUATION:

(1st Contact) Name _____ Relationship _____ **(2nd Contact)** Name _____ Relationship _____
First MI Last First MI Last

Home Phone _____ Work Phone _____ Cell Phone _____ Home Phone _____ Work Phone _____ Cell Phone _____

Place of Employment _____ Occupation_____ Place of Employment _____ Occupation _____