



Education Department Student Medical Form

Student's Name: _____ Date of Birth: _____

Parent/Guardian: _____ Phone: _____

Address: _____

Are there any **medical problems** or **conditions** of which we need to be aware? Yes No
If yes, please explain:

Is the student taking any **medications**? Yes No
Please list medications and how often they are taken:

Does the student have any **allergies**? Yes No
Please list food, medicine, and environmental allergies:

May we give your child any of the following without calling you:

Aspirin	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tylenol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ibuprofen	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Is your youth fully vaccinated for Coronavirus / COVID-19? Yes No

Names and phone numbers of **parents/guardians, relatives or friends** we may contact in case of emergency.

Name	Phone Number	Type of number	Relationship
_____	_____	home work cell	_____
_____	_____	home work cell	_____
_____	_____	home work cell	_____
_____	_____	home work cell	_____

In case of emergency, I, _____, give my permission to Ocala Civic Theatre
Name of Parent or Guardian
to obtain emergency medical treatment for my child _____.
Name of Child

Signature: _____ Date: _____