

ABILITY MENTORING DAY

MEDICAL INFORMATION



Student Name: _____

Date of Birth: _____

This form must be completed, signed, and attached to the Student Application for participation in Tioga County Ability Mentoring Day. Parental signature is required for all students under the age of 18 years.

Should it be necessary for my son/daughter to have medical treatment while participating in Tioga County Ability Mentoring Day activities, I hereby give permission to Tioga County Ability Mentoring Day Staff to use their best judgment in obtaining medical service for my son/daughter, and I give permission to the chosen medical personnel to render whatever medical treatment he or she deems necessary and appropriate. Permission is also granted to release necessary emergency contact/medical history to the attending physician, or to the job shadow site, if needed.

Name of Parent/Guardian: _____

Work Telephone/TTY _____ Home Telephone/TTY _____

Family/Personal Doctor _____ Telephone/TTY _____

Please list all allergies: _____

Please list all medications/schedule/instructions (students will supply all needed medications, please use back of sheet if necessary): _____

Please list any medical/health conditions for which we need to be aware: _____

I hereby agree to all of the above authorizations and permissions and have supplied all necessary medical information about my son/daughter.

Signature of Student (18 or over) or Parent/Guardian

Date

PLEASE
RETURN TO
TEACHER

BLAST
Intermediate
Unit 17

Northern Tioga
School District

Partners in
Progress

Southern Tioga
School District

Tioga County
Department of
Human Services

Wellsboro Area
School District

