NOTE: THIS FORM MUST BE COMPLETED, SIGNED, AND TURNED IN AT REGISTRATION. DO NOT MAIL! No student will be allowed to register without submitting this medical information. Bring it with you!!!

GANHS STATE CONVENTION
MEDICAL PERMISSION SLIP

(Please print or type)

Name:____ Age:____________ Sex: ____________
Last First Middle

Home Phone: (_______)______________________ Parent's Name(s)___________________________

Parent's Daytime Phone(s): (_______)______________________ (_______)____________________

Name and Phone Number of persons to be contacted in case of emergency (other than parents):
_______________________________________ Phone:(________)_____________________________

School I Attend:__________________________ School Phone:(_______)______________________

School Address:____
Number & Street City State Zip

School Principal:______________________________ Home Phone(______)_____________________

Who is repsonsible for medical payments? _____Individual _____Insurance

If individual, please provide credit card information: ____Visa _____Mastercard

____
Name on Card Exp. Date Cardholder's Signature

Medical Insurance Company Name:____

Address:____
Number & Street City State Zip

Policy Number:____

Physician's Name:________________________________ Phone Number:(____)_________________

Brief Medical History

Special Health Concerns:____

Medications:____________________________________ Dosage per day:________________________

Asthma: _____Yes _____No Medication:____

Diabetes: _____Yes _____No Medication:____

Epilepsy: _____Yes _____No Medication:____

Should delegate be restricted from any type of activity? _____Yes _____No

If yes, please explain:____

____

Are there any prescription or non-prescription drugs that should NOT be administered?

_____Yes _____No

Type:____

Any other pertinent information:____

____

Note: If you are taking medication regularly, please bring a supply in a labeled container.

I, the parent or legal guardian of _______________________ (my child), authorize the Georgia Association of National Honor Societies 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 that my child requires medical attention. I grant to a licensed physician 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 of such care. I release GANHS, its employees, and agents from any damages, liability, or loss resulting from their securing in good faith medical care for my child.

Printed Name of Parent Guardian:____

Signed:____

(Parent or Guardian) (Date)