



# MEDICAL RELEASE FORM

NAME OF STUDENT: \_\_\_\_\_ LAST NAME: \_\_\_\_\_

Address/City/Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Does the student have any medical conditions that would prohibit full participation in courses or athletic programs BSE offers? \_\_\_\_\_

If yes, explain: \_\_\_\_\_

PHYSICIAN'S FIRST AND LAST NAME: \_\_\_\_\_

PHONE: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

Does the child take any medication? \_\_\_\_\_

Does the child require any special accommodations? \_\_\_\_\_

Describe: \_\_\_\_\_

The information provided by me in this release form is, to the best of my knowledge, accurate and true. As indicated by my signature below, I authorize Brooklyn School of Excellence personnel to consent to any emergency treatment of my minor child,

\_\_\_\_\_, which shall in my absence be deemed necessary. This shall include examination, anesthesia, medical diagnosis, surgery or treatment and/or hospital care of the minor child and upon the advice of a physician or surgeon licensed to practice medicine in the United States of America. I acknowledge that I will be responsible for any cost incurred by this treatment. I understand that Brooklyn School of Excellence does not provide health insurance to students. This authorization shall be valid during the \_\_\_\_\_ school year only.

\_\_\_\_\_  
Signature of parent/guardian

\_\_\_\_\_  
Date