

Friendship Collegiate Academy

2017-2018 Medical Clearance Form

**Student’s Name**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:**\_\_\_\_\_\_\_\_

(Last) (First) (M.I.)

**Gender:** Male or Female **SY17-18** **Grade**: \_\_\_\_\_\_\_\_

**Student’s Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Emergency Contact Information**

(Emergency contacts will be called in the order you list them!)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  **Name** | **Relationship** | **Home Number** | **Work Number** | **Cell Number** |
| 1. |  |  |  |  |
| 2. |  |  |  |  |
| 3. |  |  |  |  |

**MEDICAL INFORMATION (Check All That Apply)**

* Diabetes
* Asthma (Inhaler Used? \_\_\_\_\_\_\_)
* Sickle Cell/ Sickle Cell Trait

**List all medications including over the counter:**

* Epilepsy
* High Blood Pressure
* Concussion