

Medical Release Form

Effective dates: _____ to _____ (Effective one year from signed)

Please print in ink:

Student's information:

Name: _____ Age _____ Birthday _____
Year in school _____ Male Female Email _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell phone _____

Medical insurance company: _____
Policy #: _____ Group #: _____
Insurance company phone number: _____

Mother's information:

Name: _____ Email _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work phone _____
Cell phone/pager: _____

Father's information:

Name: _____ Email _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Work phone _____
Cell phone/pager: _____

Emergency contact:

Name: _____ Relationship to student: _____
Home Phone _____ Work phone _____
Cell phone/pager: _____

Physician _____ Office phone _____
Dentist _____ Office phone _____

Please list any allergies (medications, food, insects, plants, etc.) _____

Please list any medications currently taken: _____

Additional comments: _____

In the event that he/she is injured and requires the attention of a doctor, I/we consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by the Church, I/we agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent. I/We also acknowledge that we will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider. Further, I/we affirm that the health insurance information provided above is accurate at this date and will, to the best of my knowledge, still be in force for the student named above.

Parent/guardian signature: _____ Date: _____

Notary signature: _____ Date: _____