

Medical Release Form

(For children under the age of 18)

Event: _____

Event Dates: _____

I understand that in the event of a medical emergency, or if any medical or surgical care becomes necessary for _____, every attempt will be made to contact me. If I am unavailable, I grant those in charge of this event permission to authorize medical attention as recommended by a licensed physician. We agree to pay all medical costs involved in such an emergency treatment. We release and discharge United Evangelical Free Church and/or its representatives involved in this event from any liability whatsoever in exercising this permission.

SIGNATURE OF PARENT OR LEGAL GUARDIAN: _____

DATE: _____

PARENT OR LEGAL GUARDIAN: _____

(PLEASE PRINT)

ADDRESS: _____

DAY PHONE: _____ EVENING PHONE: _____

CELL PHONE: _____

EMERGENCY CONTACT (Other than parent or guardian): _____

RELATIONSHIP TO YOUNG PERSON: _____

DAY PHONE: _____ EVENING PHONE: _____

The more of the following information you can provide, the better care we can give to your child.

PHYSICIAN NAME: _____

PHYSICIAN PHONE: _____

INSURANCE COMPANY: _____

POLICY NUMBER: _____

MEDICAL INFORMATION:

Date of last tetanus shot: _____

Allergies, including drug allergies: _____

Current medication with instructions for use and other pertinent medical information:

Please Note: The above information is confidential and will not be released unless it is necessary for medical purposes.