

# MEDICAL RELEASE FORM

Student's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

Parent's Name \_\_\_\_\_

Child's SSN \_\_\_\_\_

Birthdate \_\_\_\_\_ Insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_

Primary Care Physician Name & Number \_\_\_\_\_

Allergies \_\_\_\_\_

Current Medical Conditions \_\_\_\_\_

Medications \_\_\_\_\_

Date of last tetanus shot \_\_\_\_\_

Emergency Contact & Phone Number \_\_\_\_\_

Alternate Emergency Name & # \_\_\_\_\_

I/We, the undersigned, are the parents having legal custody, or are the legal guardians of

(STUDENT'S NAME)

\_\_\_\_\_, a minor, and have given our consent for him to be administered proper medical treatment, as deemed necessary by a licensed physician/doctor. I/We

(ADULT LEADER'S NAME)

authorize \_\_\_\_\_ to give consent in case we cannot be reached or because of emergency.

Student's Name: \_\_\_\_\_

Student's Signature: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_

Phone #: \_\_\_\_\_

Date: \_\_\_\_\_

**PLEASE ATTACH COPY OF CURRENT INSURANCE CARD**