MEDICAL INFORMATION
AUTHORIZATION FOR MEDICAL TREATMENT
MEDICAL/ EMERGENCY INFORMATION

Name	Medical allergies/significant medical history	Last tetanus immunization

Mother's Name ______________ Home #______________ Cell #______________

Father's Name ______________ Home #______________ Cell #______________

Name of Physician ______________________ Phone #______________________

Address ____

Medical Insurance Company ______________________________________

Insurance Number ____

Other contact in case of emergency:

Name ______________________ Phone______________________

Relationship ______________________________

MEDICAL RELEASE

In the event that the undersigned, or my (our) authorized physician, cannot be reached and in the judgment of Marsha Johnson (name of Director of Religious Education or other person responsible for the program/ group), or other appropriate staff member, there is a necessity for immediate examination and/or treatment of my (our) child, I (we) hereby request and authorize any of the aforesaid personnel to obtain for my (our) child such medical services as are deemed necessary. I agree to assume the financial responsibility for any diagnosis/treatment and for medication deemed necessary.

Date or Dates for which release is intended: September 2017 through May 2018

______________________________ ______________

Parent/Guardian Signature Date

______________________________ ______________

Parent/Guardian Signature Date