

**MEDICAL INFORMATION
 AUTHORIZATION FOR MEDICAL TREATMENT
 MEDICAL/ EMERGENCY INFORMATION**

| Name | Medical allergies/significant medical history | Last tetanus immunization |
|------|---|---------------------------|
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| | | |
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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