

# MEDICAL RELEASE FORM - CHILDREN

DATE \_\_\_\_\_

CHILD'S NAME: \_\_\_\_\_ GENDER \_\_\_\_\_ AGE \_\_\_\_\_

GRADE ATTENDING AS OF JANUARY this year \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

FATHER'S NAME: \_\_\_\_\_ CELL #: \_\_\_\_\_

PLACE OF EMPLOYMENT: \_\_\_\_\_ PHONE: \_\_\_\_\_

MOTHER'S NAME: \_\_\_\_\_ CELL #: \_\_\_\_\_

PLACE OF EMPLOYMENT: \_\_\_\_\_ PHONE: \_\_\_\_\_

LEGAL GUARDIAN OF CHILD: Parents \_\_\_\_\_ or Other \_\_\_\_\_

If other, please give name & address: \_\_\_\_\_

## IF EMERGENCY, AND PARENT'S CAN NOT BE REACHED, PLEASE CALL:

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

PHYSICIAN'S NAME \_\_\_\_\_ PHONE: \_\_\_\_\_

PLEASE LIST ANY:

ALLERGIES: \_\_\_\_\_

MEDICATIONS: **(See back of form)** \_\_\_\_\_

ANY HEALTH PROBLEMS: \_\_\_\_\_ DATE OF LAST TETANUS SHOT: \_\_\_\_\_

HOSPITAL WITH RECORDS: \_\_\_\_\_

PRIMARY INSURANCE: \_\_\_\_\_

POLICY NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

**Please Attach A Copy Of Your**  
**Insurance Card.**

I give my permission to any authorized personnel of Immanuel Baptist Church to take emergency measures deemed necessary for the care and protection of my child while under their supervision. In case of accident or illness, I understand that my child will be taken to an appropriate medical facility for treatment. It is understood that in severe situations, the adults in charge may contact the local emergency resource before the parent, child's physician, and other adults acting on the parent's behalf.

I understand that any expenses incurred will be the responsibility of the child's family.

PARENT'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

NOTARY: \_\_\_\_\_ STATE: \_\_\_\_\_ COUNTY: \_\_\_\_\_

DATE: \_\_\_\_\_ MY COMMISSION EXPIRES: \_\_\_\_\_

**NOTE: THIS RELEASE WILL REMAIN IN EFFECT UNTIL December 2020**

**Please list ALL medications  
you are currently taking.**

[illegible]