

Medical Release Form

(For children under the age of 18)

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 Community of Hope Lutheran Church and the Evangelical Lutheran Church in America 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 _____

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 except in case of emergency.