Clarence Presbyterian Church Medical Release Form

I, ___________________________________of ____
Parent/Guardian Name Address City State Zip

am the _________________________ of ____
Relation Child's Name

of ____.
Address City State Zip

I hereby give my consent, in the event of all reasonable attempts to contact me have been unsuccessful, for immediate medical treatment as required in the judgment of the attending physician while ______________________________ is absent from home _____ to _______.
Child's name date date

Child's date of birth: _____________________

Parent/Guardian Phone Number(s): Work: (___) ________________ (___) ______________

Home: (___)_______________________________ (___)______________________________

Cell: (___)________________________________ (___)_______________________________

Family Physician: __________________________ Family dentist: _______________________

Address: _________________________________ ____________________________
Street Street

____ ____________________________
City, State, ZIP City, State, ZIP

Phone: (___)_______________________________ (___)________________________

Medical Insurance Company ____

Address: ____

Phone: ____

Policy number: ____

Name of insured: ____

The following information is needed by any hospital or practitioner not having access to medical history: (for additional space, used an attached page or back of page).

Allergies: ____

Prescription Medications: ____

____

Over the counter medications: ____

____

Does child carry medication with him/her? _____ Can child self medicate? ________________

If not, directions for giving medication: ____

Date of last tetanus shot: ____

Physical, impairments which may affect the well-being of the child: ______________________

____

Other pertinent fact to which physician should be alerted:_______________________________

____

If parent/guardian cannot be reach in case of emergency, call:

_________________________________ (___)_______________ (___)_________________
First Choice Name Area Code Phone Additional number

_________________________________ (___)_______________ (___)_________________
Second Choice Name Area Code Phone Additional number

In a medical emergency, I consent to the chaperone or appointed agent, his, her or their discretion in using, taking, arranging for or consenting to the procedures or treatment.
I agree to indemnify and hold harmless Clarence Presbyterian Church, the individual members, agents, employees and representatives thereof, for any and all claims, demands, actions, rights of action and/or judgments by or on behalf of the above named member arising from or on account of said procedures and/or treatment rendered in good faith and according to accepted medical standards.

I assume the total financial responsibility for the above named member and will not hold Clarence Presbyterian Church responsible in the event of a medical emergency.

____
Signature of Parent/Guardian Date

____
Social Security Number of Parent/Guardian (optional)