

# Medical Release Form

Student's Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Parent/Legal Guardian \_\_\_\_\_

Home Phone \_\_\_\_\_ Parent Work phone \_\_\_\_\_

Mobile phone \_\_\_\_\_

Taking any medication currently Yes No Please list \_\_\_\_\_

Allergies (Food, Medical, other) \_\_\_\_\_

Doctor \_\_\_\_\_ Phone: \_\_\_\_\_

Address \_\_\_\_\_

Insurance Information: (please include a copy of your insurance card – both sides where applicable)

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Date of last Tetanus \_\_\_\_\_

Other emergency Contact person:

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Phone: \_\_\_\_\_

I (parent or guardian), \_\_\_\_\_ do hereby give my permission for \_\_\_\_\_ to receive necessary medical care as deemed necessary by a licensed physician, surgeon, or dentist. I further authorize the leaders of New Highland Baptist Church to seek this care as needed. I also agree to be responsible for any associated expense, claim, or liability arising from needed care.

\_\_\_\_\_  
Parent/Guardian signature

\_\_\_\_\_  
Date

