

## Medical Release Form

Family's Last Name \_\_\_\_\_

\_\_\_\_\_  
Mother or Guardian's Name

\_\_\_\_\_  
Home Phone #

\_\_\_\_\_  
Cell Phone #

\_\_\_\_\_  
Employer

\_\_\_\_\_  
Work Phone #

\_\_\_\_\_  
Father of Guardian's Name

\_\_\_\_\_  
Home Phone #

\_\_\_\_\_  
Cell Phone #

\_\_\_\_\_  
Employer

\_\_\_\_\_  
Work Phone #

If unable to reach parents, emergency contacts

Name \_\_\_\_\_

Phone # \_\_\_\_\_

Relationship to child \_\_\_\_\_

Name \_\_\_\_\_

Phone # \_\_\_\_\_

Relationship to child \_\_\_\_\_

Please provide the name of your child(ren)'s family doctor, family dentist and hospital preference.

Family Doctor \_\_\_\_\_

Phone Number \_\_\_\_\_

Family Dentist \_\_\_\_\_

Phone Number \_\_\_\_\_

Hospital Preference \_\_\_\_\_

I hereby authorize treatment for my son(s)/ daughter(s) for any emergency medical situation that might arise at a time when I cannot be contacted.

Check:  Yes  No

Parent or Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

**Please return to a Sunday school teacher or Marlene Dadey**