

MEDICAL RELEASE FORM

Antioch Church of Christ

Date _____

Child's Name (complete) _____

Address _____

City _____ State _____ Zip _____

Phone _____ Birth Date (mm/dd/yy) _____

Health Insurance _____

Social Security # (of child): _____ Group Number: _____

Identification Number: _____

Name of Cardholder (parent): _____

Social Security # of Cardholder: _____ Birth date of Cardholder (mm/dd/yy): _____

Address of Insurance Company: _____

List all medications currently using: _____

List any allergies: _____

Last tetanus shot: _____

Any other facts concerning the child's medical history to which a physician should be alerted:

I understand that in the event medical treatment is needed, every attempt will be made to contact me and the alternate contact listed on this form. In the event I cannot be reached in an emergency, I hereby give permission to the physician or dentist selected by the activity leader to hospitalize, to secure medical treatment and/or to order an injection, anesthesia, or surgery for my child as deemed necessary. I understand that my insurance coverage for my child will be used as primary coverage in the event medical treatment is needed.

I understand all reasonable safety precautions will be taken at all times by Antioch Church of Christ and its agents. I understand the possibility of unforeseen hazards and know the inherent possibility of risk. I agree not to hold Antioch Church of Christ, its leaders, employees, and volunteer staff liable for damages, losses, diseases, or injuries incurred by the subject of this form.

Parent/Guardian Signature: _____ Date: _____

Signature of Student: (if over 18) _____

Parent/Guardian Name: _____

Address: (only if different from above): _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Alternate Contact Person: _____

Phone: _____