PRINCE OF PEACE
LUTHERAN CHURCH AND PRESCHOOL

Youth Medical Release

As the parent/legal guardian of

_____

I request that in my absence the above-named dependent to be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. This care may be given under whatever conditions are necessary to preserve the life, limb, or well being of my dependent. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named dependent.

It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, be that any of the above treatment will not be withheld if the undersigned cannot be reached.

_____
Date (This consent shall remain effective for 1 year)

_____
Name of Father, Mother or Legal Guardian

_____
Signature of Father, Mother or Legal Guardian

_____
Address

_____
City, State, Zip

_____
Phone

_____
E-mail Address

Medical Information:

NAME: _____

DATE OF BIRTH: _____

DATE OF LAST TETANUS BOOSTER: _____

BLOOD TYPE: _____

FAMILY PHYSICIAN: _____

PHONE: _____

KNOWN ALLERGIES TO DRUGS OR FOOD: _____

_____

CURRENT MEDICAL ISSUES: _____

_____

_____

INSURANCE COMPANY: _____

POLICY NUMBER: _____

Emergency Contact:

_____
NAME

_____
RELATION

_____
CELL PHONE