

LAKWOOD UNITED METHODIST CHURCH
STUDENT MINISTRIES
MEDICAL RELEASE FORM

Name: _____ D.O.B. _____ Sex: _____

Address: _____ City: _____ Zip: _____

Student's Age: _____ Grade: _____ Date of Last Tetanus Booster: _____

Home Phone: _____ Parent's Cell Phone: _____

Parent/Guardian: _____

Mother's Work Phone: _____ Father's Work Phone: _____

Emergency Contact (other than parents)

Name: _____ Phone Number: _____

Name of Insurance Company: _____ Policy/Group Number: _____

Name of Insured: _____ Insured's SSN: _____

Allergic to the Following Medications: _____

Note any specific allergies or other health comments: _____

In the event of an emergency, I give permission to the representatives of Lakewood United Methodist Church to care for my child and to seek emergency help as needed. I also give permission for my child to be taken to a hospital and treated by an attending physician.

Parent/Guardian Signature: _____ Date: _____

NOTARIZATION

County of _____ State of: _____

Before me, the undersigned authority, on this day personally appeared _____

_____, known to me to be the person whose name is subscribed above, and acknowledged to me that he/she executed the same for the purpose therein expressed. Sworn and subscribed before me this _____ day of _____, 200__

Notary Public

Date Commission Expires