

Porterfield Memorial United Methodist Church
2200 Dawson Road
Albany, GA 31707
229-436-6336

Medical Release Form 2017 - 18

Student's Name _____
(First name) (Middle name) (Last name)

Parents Name (M) _____ (F) _____

Street Address _____

City _____ State _____ Zip _____

Grade _____ Date of Birth ____/____/____ T-Shirt Size _____

(M) cell _____ text ok? _____ (F) cell _____ text ok? _____

Email address (M) _____
(F) _____

Emergency Contact Person (other than parent) _____

Phone # _____

Insurance Company _____ Policy Number _____

Comments, Allergies, and/or Medical Information:

Should the need arise; I give permission for my child to be given medical treatment and/or taken to a doctor/hospital for such treatment. In the event I cannot be reached I hereby authorize the representative of Porterfield Memorial United Methodist Church to consent to such treatment.

I have read the above, understand it fully and sign it voluntarily.

Parent/Guardian
Signature: _____ Date: _____

Notary Signature: _____

**Please complete ALL information and
attach a copy of your insurance card.**