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

Medical Release Form 2018 - 19

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** ______________________

(Mo) cell _________________ **text ok?** _______ **(Fa) cell** _____________________ **text ok?** _______

Email address: (Mo) ____

(Fa) ____

Emergency Contact Person (other than parent) ____

Cell Phone # ______________________ **Other contact** ______________________________________

Insurance Company ___________________________**Policy Number**___________________________

Comments, Allergies, and/or Medical Information:

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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.