

# Contagious Student Ministry Medical Release Form

## Contact Information

Student Name

Parent/Guardian Name

Address

City, State, Zip

Student Birth Date

Age

Gender

Daytime Phone

Evening Phone

## Medical History

Are you currently taking any medicine or treatment?

YES

NO

Have you been restricted from travel, sports or exercise for any reason?

Have you ever had a severe reaction to a bee sting or insect bite?

Do you suffer from motion sickness?

Do you have any known allergies?

Do you have any of the following:

Asthma

Sinus Trouble

Hay Fever

Heart Trouble

Communicable Disease

Diabetes

Epilepsy

If you answered "Yes" to any of these questions, please explain:

## Insurance Information

Insurance Company

Card Holder's Name

Policy #

Group # (If Applicable)

Address to Submit Claims

## Emergency Treatment Authorization

I, \_\_\_\_\_, parent/guardian of \_\_\_\_\_, hereby give Contagious Student Ministry/FSBC and/or its' agents, permission to obtain medical assistance for my child. I also give permission to the Physician selected by the CSM/FSBC and/or its' agents, to provide hospitalization and secure the proper treatment for my child.

Signature \_\_\_\_\_

State of \_\_\_\_\_

County of \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_, \_\_\_\_\_ personally appeared before me, a Notary Public, within and for the State and County aforementioned, and acknowledged that he or she freely and voluntarily executed the same for the purposes stated therein.

Commission Expires: \_\_\_\_\_

SEAL:

\_\_\_\_\_  
Notary Public