

Medical Release Form

Contact Information

Name _____ Address _____
Age ____ Grade ____ Sex ____ Date of Birth _____
Phone # _____
Mother's Name _____ Address _____
Mother's Phone _____ Office _____ Cell _____
Father's Name _____ Address _____
Father's Phone _____ Office _____ Cell _____
Emergency Contact (other than parent) _____
Address _____ Phone # _____
Office # _____ Cell# _____

Insurance Information

Subscriber Name (Name in whom insurance is listed): _____
Insurance Carrier _____ Group Name (employer) _____
Insurance Number _____
Address for claims _____

***Please photocopy front and back of your insurance card and attach to this form...**

Medical Information

ANY MEDICATION NEEDS TO BE LABELED AND IN A ZIP-LOCK BAG. THESE ARE TO BE TURNED IN WITH INSTRUCTIONS AT REGISTRATION.

Drug Allergies _____
Medications taken on a regular basis (list below):
Medication _____ Dosage _____ Times _____
Medication _____ Dosage _____ Times _____
Medication _____ Dosage _____ Times _____

Physician's Name _____ Phone # _____
Date of last Tetanus/ Booster _____

Parental Consent

This health history is correct to the best of my knowledge. I hereby give permission to the Staff and Volunteers of Hawkinsville First United Methodist Church to consent for medical treatment by a physician or hospital on the above listed minor child. I agree to release any and all records necessary for insurance purposes.

Signature of Parent/Guardian _____

Printed Name _____ Date _____

** Please list any food allergies, dietary restrictions, and any other restrictions on the back of this form.*