

Medical Release Form

Form #: FMT_201102_01_200102 First Approved:2/26/01 as OP-01-03

Approved: 02/28/2011

In case of medical or dental need or injury, I understand that Holy Cross Lutheran Church will make a reasonable effort under the circumstances to contact me (in case of an injury to my child) or emergency contact (in case of my own injury). In the event that I or my emergency back-up contact cannot be reached, I authorize the Holy Cross Lutheran Church to arrange for medical services for me or any of my children listed below. I will be responsible for any medical and other expenses for me or my child. Any provider of care can rely on this Consent as conclusive authority to treat me or my child as appropriate and to bill me directly for the costs thereof. I agree that I am responsible for communicating any food allergies or other relevant medical conditions pertaining to me or my child to the Holy Cross Lutheran Church staff or representative using this form.

Parents' or Legal Guardians' Names (if a minor) _____

Address: _____ Phone: _____

Phone number(s) where you can be contacted: _____

Medical Insurance Company, Group Number and / or Policy number:

Family Physician: _____ Phone Number: _____

Address: _____

Family Dentist/Orthodontist: _____ Phone Number: _____

Address: _____

Participant #1:

Participant's Name: _____

Authorized Medication and Time They Should Be Administered: All medicine must be in its original container, clearly marked with the person's name and dosage to be given and turned into the activity sponsor.

Name of medication:	Time(s) of administration:
_____	_____
_____	_____
_____	_____

Do you or your child have any allergies or special medical conditions of which we should be aware?

May the church give your child Tylenol or aspirin for headaches or pain?

YES

NO

Date of participant's last Tetanus shot (month/year): _____

Participant #2:

Participant's Name: _____
Authorized Medication and Time They Should Be Administered:

Names of Medicine:

Time(s) of Administration:

Do you or your child have any allergies or special medical conditions of which we should be aware?

May the church give your child Tylenol or aspirin for headaches or pain?

YES

NO

Date of participant's last Tetanus shot (month/year): _____

Participant's Signature: _____ **Date:** _____

Participant's Signature: _____ **Date:** _____

Parent's or Guardian's Signature: _____ **Date:** _____

Update: by signing this update, I have looked over the above information and agree all information is still current and correct.

Participant's Signature: _____ **Date:** _____

Participant's Signature: _____ **Date:** _____

Parent's or Guardian's Signature: _____ **Date:** _____

Update: by signing this update, I have looked over the above information and agree all information is still current and correct

Participant's Signature: _____ **Date:** _____

Participant's Signature: _____ **Date:** _____

Parent's or Guardian's Signature: _____ **Date:** _____