

## Harmony Baptist Church Medical Release Form (This information will be kept on file at the church)

**Parent/Legal Guardian Information**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone Numbers: Home: ( ) \_\_\_\_\_ - \_\_\_\_\_

Parent/Guardian Her Cell: ( ) \_\_\_\_\_ - \_\_\_\_\_

His Cell: ( ) \_\_\_\_\_ - \_\_\_\_\_

Her Work: ( ) \_\_\_\_\_ - \_\_\_\_\_

His Work: ( ) \_\_\_\_\_ - \_\_\_\_\_

Student's Name(s)	List all known medical conditions, including food and/or drug allergies	Include any and all over-the-counter drugs and/or prescription drugs taken regularly

In an emergency, please contact: \_\_\_\_\_

Relationship to student(s): \_\_\_\_\_

Phone #s: ( ) \_\_\_\_\_ - \_\_\_\_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_  
( ) \_\_\_\_\_ - \_\_\_\_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_

Or Contact: \_\_\_\_\_

Relationship to student(s): \_\_\_\_\_

Phone #s: ( ) \_\_\_\_\_ - \_\_\_\_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_  
( ) \_\_\_\_\_ - \_\_\_\_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_

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Physician's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone #s: ( ) \_\_\_\_\_ - \_\_\_\_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_

Dentist's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Phone #s: ( ) \_\_\_\_\_ - \_\_\_\_\_ ( ) \_\_\_\_\_ - \_\_\_\_\_

Harmony Baptist Church  
Medical Release Form

Primary Insurance Company: \_\_\_\_\_  
Phone #s: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_  
Billing Address: \_\_\_\_\_  
Policy Holder's Name: \_\_\_\_\_  
Relationship to student(s): \_\_\_\_\_  
ID #: \_\_\_\_\_ Group/Policy #: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_  
Phone #s: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_  
Billing Address: \_\_\_\_\_  
Policy Holder's Name: \_\_\_\_\_  
Relationship to student(s): \_\_\_\_\_  
ID #: \_\_\_\_\_ Group/Policy #: \_\_\_\_\_

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Statement of Consent:

In the event of an emergency or non-emergency situation requiring medical treatment, I, \_\_\_\_\_, hereby grant permission for any and all medical and/or dental attention to be administered to my child/children, in the event of an accidental injury or illness, until such time as I can be contacted. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_