

Medical Release

(to be signed by parent)

I (we) understand that, in the event that medical treatment is required, every effort will be made to contact me. If I cannot be reached, however, I give permission to the Faith staff or youth sponsor to give first aid to my child and/or to secure the service of a licensed physician to provide the necessary care, including anesthesia, for my child's well-being. I also understand that all medical expenses will be my responsibility.

Signed

Date

Student's Name

Emergency contact person

Daytime phone

Insurance company

Policy #

Allergies/Medical problems

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