South Attleboro Assembly of God

STUDENT MEDICAL RELEASE FORM

Name of Student: _____ Date: _____

The above named child has my permission to engage in all prescribed South Attleboro Assembly of God activities except as noted by me. I certify that I am the parent, legal guardian, or otherwise have the legal authority to sign this authorization on behalf of the child named above.

In the event of illness or accidental injury, I hereby authorize South Attleboro Assembly of God and/or its leaders to act for me in my behalf as the parent or other person having legal authority to act for the child named above in securing medical treatment. In the event of an emergency, I hereby give permission to the physician selected by South Attleboro Assembly of God hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery for the child named above.

All bills will be sent to the parents or guardians for payment or forwarding to your insurance company. Please print clearly.

Parent/Guardian Signature: _____ Date: _____

1. Do you carry accident insurance? Yes _____ No _____
   Name of Insurance Company _____
   Address _____
   City/State/Zip _____ Phone _____
   Policy Number _____

2. Do you carry medical insurance? Yes _____ No _____
   Name of Insurance Company _____
   Address _____
   City/State/Zip _____ Phone _____
   Policy Number _____

3. Do you carry dental insurance? Yes _____ No _____
   Name of Insurance Company _____
   Address _____
   City/State/Zip _____ Phone _____
   Policy Number _____

   Parent/Guardian's place of employment under which insurance is covered:
   _____ Phone _____

STUDENT MEDICAL INFORMATION

Name: _____ Birth Date: _____ Age: _____ Sex: _____
Parent/Guardian Name: _____ Home Phone: _____ Work Phone: _____
Parent/Guardian Cell Phone: _____ Email Address: _____
Home Address: _____ City/State/Zip: _____

If not available in an emergency, please notify:

1. Name: _____
   Address: _____ City/State/Zip: _____
   Cell Phone: _____ Home Phone: _____

2. Name: _____
   Address: _____ City/State/Zip: _____
   Cell Phone: _____ Home Phone: _____

Operations/Serious Injuries (dates): _____
_____

Chronic or Recurring Illnesses: _____
_____

Allergies: _____

Allergies to Medications or Insect Sting: _____

Special Diet: _____
_____

Special Medication (Name and how to administer): _____
_____