Santa Clara First Baptist Church Medical Release

FAMILY INFORMATION		
Name of Student:		Birth Date: / /
Name of Parents:		
Address:		Home Phone:
City: State: Zip Code:		Work Phone:
In case of an emergency and parents are not available, contact this person:		
Name:	Phone:	Relationship:

PHYSICIAN / DENTIST / MEDICAL & INSURANCE INFORMATION		
Physician:	Address:	Phone:
Dentist:	Address:	Phone:
Medical Insurance Plan:		
Subscriber Number:	Group Number:	
Emergency Hospital Preference:		Phone:
Action if Physician cannot be reached:		
Known Allergies:		Last Tetanus: / /
Allergic to any medications? Yes No		
If yes, which medications?		
Describe continuing medical conditions and medications:		
Describe any other important information:		

AUTHORIZATION FOR MEDICAL TREATMENT

I hereby authorize the treatment of all emergency dental or medical care prescribed by a duly licensed physician or dentist for my minor child, listed above, in the event of a medical situation occurring in my absence or when the hospital or physicians are unable to contact me. This authorization extends to any hospital, physician(s), and nursing personnel within the physician's staff where treatment is rendered in the physicians. I release from medical responsibility and liability the hospital, physician(s) and nursing personal for performing medical procedures and acting on the authority of this medical treatment consent form which such medical providers deem necessary for my minor child.

Signed this _____ day of _____ 2005, and valid through June 30, 2006

_____

Signature of parent/guardian Date