



# STUDENT-AUTHORIZATION FOR EMERGENCY MEDICAL CARE AND MEDICAL RELEASE

## THIS RELEASE EXPIRES JUNE 1, 2019

LAST NAME \_\_\_\_\_ FIRST NAME \_\_\_\_\_ BIRTHDAY \_\_\_\_\_ GRADE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

PARENT OR GUARDIAN \_\_\_\_\_ WORK PHONE \_\_\_\_\_ PARENT CELL PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ ZIP \_\_\_\_\_

Parents Email: \_\_\_\_\_

IN CASE OF EMERGENCY, NOTIFY \_\_\_\_\_ RELATIONSHIP TO STUDENT \_\_\_\_\_

PHONE \_\_\_\_\_ FAMILY DOCTOR \_\_\_\_\_ PHONE \_\_\_\_\_

PREFERRED HOSPITAL \_\_\_\_\_ HEALTH INSURANCE: SUBSCRIBER \_\_\_\_\_

Date of last tetanus shot: \_\_\_\_\_ Swimming restrictions? Yes \_\_\_ No \_\_\_ Activity restrictions? Yes No Explain: \_\_\_\_\_

If any of the above are checked, please give details (including normal treatment of allergic reactions, name and dosage of medications that must be taken, etc.) \_\_\_\_\_

I understand that, in the event medical treatment is required, every effort will be made to contact me. In the event that I cannot be reached, I hereby give my permission for the staff of Laurelglen Bible Church to consent to any hospital care, medical treatment and/or injections, anesthesia, or surgery for my child as deemed necessary by and as rendered under the general or special supervision of any licensed physician or surgeon. It is understood that this authorization is being given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of the authorized agent(s) to give specific consent to any and all such diagnosis, treatment, or hospital care which the physician in the exercise of his best judgement may deem advisable. This authorization shall remain in effect until June 1, 2019 unless revoked in writing.

(A photocopy of this form is as valid as an original)

Parent or guardian's signature \_\_\_\_\_ Date \_\_\_\_\_