# MEDICAL RELEASE CONSENT FORM

**(September 2022 – August 2023 School Year)**

## (2022 - 2023 SCHOOL YEAR) – GRADE _____

NAME _____

ADDRESS _____

CITY STATE ZIP _____

HOME PHONE _____

AGE _____ BIRTH DATE _____

PARENT(S) BUSINESS PHONE _____

To Whom It May Concern:

The undersigned does hereby give permission for our (my) child, _____ to attend and participate in any activities planned and sponsored by the Wilmington Church of Christ during the time period stated above.

We (I) authorize an adult, in whose care the minor has been entrusted, to consent to any X-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

The undersigned shall be liable and agrees to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

Should it be necessary for our (my) child to return home due to medical reasons or otherwise, the undersigned shall assume all transportation costs.

The undersigned does also hereby give permission for our (my) child to ride in any vehicle designated by the adult in whose care the minor has been entrusted while attending and participating in activities by the Wilmington Church of Christ.

I grant consent to the use of photographs/videos of our (my) student taken during the year for publicity and promotional purposes (including publications, presentations, internet or other media sources.)

Parent/Guardian Signature: _____

Hospital Insurance _____

Insurance Company _____

Address _____

Phone Number _____

Policy Number _____

Participant _____

Father _____

Father's Date of Birth _____

Mother _____

Mother's Date of Birth _____

Legal Guardian _____

Name and telephone number of individual to contact in case of an emergency

_____

_____

Date: _____

Please list any allergies or special medical problems in the space below: