

Medical Release Form

As a parent/guardian of _____, I request that in my absence the above named student be admitted to any hospital facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment.

Date of Birth ____/____/____ Date of last Tetanus Booster ____/____/____

Known allergies of this student, including any allergies to medicine _____

Any other medical conditions which should be noted _____

Family Physician _____ Phone () _____

Name of Parent/Guardian _____

Address _____ City/State/Zip _____

Phone () _____ H () _____ W () _____

Person responsible for charges (if different from above) _____

Address _____ City/State/Zip _____

Phone () _____ H () _____ W () _____

Person to notify if chaperone is unavailable _____

Phone () _____ H () _____ W () _____

Insurance carrier _____ Policy Number _____

Group # _____

Signature of Parent/Guardian _____

This form is valid for all school-related trips and functions from August 2022 to June 2023.