Medical Release Form

Parental Authorization:
I hereby give my permission for ___________________________to attend Trinity Student Ministries functions. In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by a sponsoring adult to hospitalize, secure proper treatment for, and to order injections, anesthesia, or surgery for my child as named above.

____ ____________________________
Parent or Guardian Signature Date

Student Information:
Name: _______________________________________ Birthday: ________________ Gender ______
Parents Names: ____
Address: ____
Home Phone: _________________Cell Phone: _______________Work Phone: __________________

Health History: (Check those that apply)

Heart Problems: ______________ Epilepsy/Convulsions: _________ Rheumatic Fever: _____________
ADHD: _____________________ Asthma: ____________________ Cancer/Leukemia: ____________
Diabetes: _________ Type 1 or 2 Insulin (How much and when): _______________________________
Other: ____

Immunizations: (Date of last inoculation)

Tetanus: ____________________ Diphtheria: __________________ Whooping Cough: ____________
Mumps: ____________________ Measles: ____________________ Rubella: _____________________
Polio: ______________________ Hepatitis B: _________________ Other: ______________________

Allergies:

Environmental: ____
Foods: ____
Medications: ____

Medications Currently Taking: (Name and Dosage)

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Family Physician: _________________________________ Phone Number: _______________________
Health Insurance Co.: ____
Name of Insurance Policy holder: ____
Insurance Co. Address/Phone: ____
Policy/Member ID#: ____________________________ Group # (if app): __________________________