

Your Church's Name

Address

City, State and Zip Code

Phone Number

## MEDICAL RELEASE STATEMENT

\_\_\_\_\_  
(Name of Minor Child)

\_\_\_\_\_  
(Date of Birth)

\_\_\_\_\_  
(Address, City, State, Zip)

\_\_\_\_\_  
(Grade)

**To: Any military, government, public or private hospital and doctors**

I hereby authorize the performance of any necessary emergency medical surgical procedures under local and general anesthesia, which may be advised by the attending physicians of my minor child while a patient of any U.S. hospital. Furthermore, I respectfully request the use of any of the hospital's services or facilities, which may be regarded as necessary, or beneficial in the performance of said procedure.

I agree to hold the hospital and doctors harmless from any liability in the treatment or admissions of my above named minor when practicing medicine according to current standards and knowledge.

I give permission for the adult in whose care the minor has been entrusted to speak on my behalf in the event of any emergency.

Let this be your authority to treat and admit my minor child, until I am able to arrive at your hospital and formally sign the necessary papers. It is understood that this authorization is given in advance of any specific diagnosis or emergency treatment being rendered.

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

Allergies: \_\_\_\_\_

Chronic Illnesses: \_\_\_\_\_

Drugs and/or Medicines currently being taken: \_\_\_\_\_

When are they taken: \_\_\_\_\_

Minor is permitted to take Tylenol or Advil for headache: Yes \_\_\_\_\_ No \_\_\_\_\_

Minor is permitted to take \_\_\_\_\_ for fever.

Minor is permitted to take \_\_\_\_\_ for cold and flu symptoms.

Is minor subject to motion sickness? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, medication permitted to take \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospitalization Carrier: \_\_\_\_\_ Policy No. \_\_\_\_\_

Name of Insured: \_\_\_\_\_ Phone: \_\_\_\_\_

Parent or Legal Guardian (print or type name) \_\_\_\_\_

Address, City, State and Zip \_\_\_\_\_

Work Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

Parent or Legal Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_

This form is good for one year