Elma ALLIANCE CHURCH
Rev. 3:7-8

315 No. 3rd St., P.O. Box 460
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MEDICAL RELEASE FORM

Student's Name: _____ D.O.B.: __/____/____ Gr:__

Home Phone: (_____)_____-_____ Cell Phone: (_____)_____-_____

Address: _____

Parents'/Guardians' Names: _____

Address (if different from child's): _____

Insurance Company: _____

Policy #: _____ Insured: _____

1. Please circle/list any allergies your child may have:
   Bee Sting / Pollens / Hay / Straw / Other _____
   Penicillin / Other Drugs _____
2. Does your child have any *life-threatening* allergies? YES / NO
   If yes, to what? _____
3. Is your child bringing any medication with him/her? YES / NO
   If yes, please list and state dosage: _____
   _____
   PLEASE NOTE: Medication should be in its original prescription bottle/package, which should have administration instructions and the child's name clearly indicated.
4. Does your child have any physical, emotional, mental or behavioral concerns or limitations that our staff should be aware of? YES / NO
   If yes, please explain: _____
   _____
5. Please circle if your child has ever had:
   Seizures / Asthma / Diabetes / Homesickness / Heart disease
   Other: _____
6. Date of last tetanus shot: _____

In the case of medical emergency, I understand that hospital policy requires parental permission before treatment. I hereby give my permission to a representative of *Elma Alliance Church* to administer medication as identified above (see #3) and to secure proper medical treatment.

It is also understood that every precaution will be taken for the safety and well-being of my child, but in the event of accident or sickness, *Elma Alliance Church, its staff and its volunteers* are hereby released from any liability.

Parents will be notified immediately of any medical emergency.

Signature of Parent/Guardian: _____

Date: _____ Emergency Phone: (_____)_____-_____

Person to contact if parent/guardian cannot be reached: _____

Relationship: _____ Phone: (_____)_____-_____