MEDICAL RELEASE FORM
EBENEZER ARP CHURCH

Name_______________________________________ Male___ Female___

S.S. # ____________________________ Date of Birth ______________

Date of last Tetanus shot: ________________

Parents Name(s) ____

Address ___________________________________ Telephone (h) __________________

City, State _________________________________ (cell) ________________

Someone else we may contact in case of emergency:

Name:____
Address: ____
Telephone: (h)_____________________(w)______________________
Relationship: ____

Medications currently taken: ____

Any Allergies or known medical conditions: ____________________________________

Insurance Co. ________________________________ Policy Number _______________

Medical Policy: In case of medical emergency, I understand every effort will be made to contact parents/guardians or relatives. In the event I cannot be reached, I hereby give permission to the Group Leader (name) _____________________ to hospitalize and secure proper treatment for my child/relative as named above. I also confirm that the above information is both complete and correct.

__________________________________ ____________________
Parent/Guardian signature Date