

Medical Release Form

Parent's Name: _____

Student's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Numbers: Home: (____) _____

Work: (____) _____

Cell: (____) _____

Name of Church: _____

Please list all known Medical conditions, including Food Allergies and/or Drug Allergies. In addition, include any and all over-the-counter medication and prescription drugs and the times they need to be taken. Please include any medication that is taken on an as needed basis.

Name of Medication	Time to be taken

Statement of Consent:

I, _____, grant permission for any and all medication(s) listed above (prescribed and over-the counter medications) to be administered to my child in my absence. This permission includes, but is not limited to, the administration of first aid and the use of an ambulance in the event of an emergency or non-emergency situation requiring medical treatment.

Signature: _____

Date: _____

