COMMUNITY**BIBLE**CHURCH
MEDICAL RELEASE FORM

This form expires December 31 of the year in which it was executed.

Participant's Name			
Street Address	City	State	Zip
Home Phone	Birthdate	Social Security No:	
Names of Parents or Guardians	Home Phone(s)	Work Phone(s)	
Other Emergency Contact Person	Home Phone(s)	Work Phone(s)	
Medical Insurance Company	Policy Number		

Please attach to this form a copy of both sides of your insurance card if you have one. This information can sometimes accelerate treatment.

Primary Care Physician	Phone	Date of last tetanus shot

NECESSARY MEDICAL INFORMATION List any pertinent conditions, especially any of the following: asthma, diabetes, fainting, heart trouble, convulsions, seizures, bleeding disorders, allergy to medication, food, plant, animal or insect toxin, any condition requiring special care, medication, or diet. List any medications the student is currently taking or will be taking during the activity. List any surgery the participant has had, when it was, and what for. Attach additional pages if necessary.

OTHER THINGS WE SHOULD KNOW For example, does the participant have any difficulty with eye, ear, nose, throat, lungs, digestion, bed-wetting, sleep-walking, etc.? Does the participant need to restrict his/her activity in any way for any medical or other important reason? Is the participant having any mental, emotional or psychological difficulties we should be aware of or sensitive to? Please feel free to mention anything you would like us to know that would help us care for your child. These things will be held in strict confidence and shared with the relevant staff on a "need to know" basis. Attach additional pages if necessary.

CONSENT TO TREATMENT

I hereby grant permission to the physician selected by any Community Bible Church adult leader presenting this document to render such care deemed necessary by the physician, including but not limited to routine diagnostic procedures, hospitalization, or out-patient services. I authorize the release of medical information contained herein for the completion of insurance claims

____
Print Parent or Guardian's name

____
Signature (sign in presence of Notary) Date

NOTARY

In the State of ______________________________

County of ______________________________

On this the _____ day of ________, ________, personally appeared before me, ______________________________

personally known by me, and in my presence executed the within and foregoing document. Witness my hand and official seal this _____ day of ________ , ________.

My commission expires _____/_____ /_____

____
Notary Public