Good Samaritan United Methodist Church

2009-2010 MEDICAL RELEASE FORM—Student Impact Valid September 1, 2009—August 31, 2010

Name: ____

Date of Birth: ____

Address: ____

City/Zip ____

Social Security Number: ____

Home Phone: ____

Father's Name: ____

Mother's Name: ____

Emergency Phone (s): ____

Email: ____

Child's email: ____

If the address or home phone for either parent is different than that of the child, please provide this information:

Address: ____

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Home or Work Phone: ____

Relationship: ____

Emergency Phone (s): ____

Person to contact if parent(s) is/are unavailable: _____________________________________

I have read and understood all sections of this form that apply to my child. I certify that the above-named youth is my child or my legal ward and resides with me. In the event he/she becomes ill, is injured or for any reason requires medical treatment while attending a Good Samaritan United Methodist Church function or activity, the undersigned parent(s) and/or legal guardian(s) of the above-named youth do hereby consent to any and all medical or surgical treatment, including anesthesia and operations which may be deemed advisable by any qualified physicians selected by agents or officials of the Good Samaritan United Methodist Church. In the event treatment is called for which a physician or other health care provider refuses to administer without my/our consent, I/We hereby authorize an official chaperone (21 or older) accompanying the Good Samaritan United Methodist Church, to give such consent and further agree to hold any person harmless from any claims, demands, or suits of any nature arising from the giving of such consent so long as the treatment is administered by or under the supervision of a licensed physician. The intention of this release is to grant

authority to administer and perform any and all examinations, treatments, anesthetics, operations, and by diagnostic procedures which may now or during the course of the patient's care, be deemed advisable or necessary by any qualified physician. Payment for all charges incurred for medical treatment is guaranteed by the parent/guardian or insurance company providing coverage for the above-named youth.

Medical/Health Insurance Co. name: ____

Policy/Group No: ____

HMO Emergency Authorization Phone number: _____________________________________

In connections with the provision of such medical treatment, be advised of the following regarding

the above-named youth: ____

Handicap, limitation or medical condition: ____

Allergies (general or to a medication): ____

Taking the following medication (medication name and dosage):___________________________

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Glasses/Contact Lens: ____

Signature of Parent: ____

Notary

Sworn to and subscribed before me this _____ day of _____________________, ____. My Commission expires: ______________
PRINT, TYPE OR STAMP COMMISSIONED NAME OF NOTARY
Before me personally appeared ________________________________ WHO IS PERSONALLY KNOW TO ME ______ or
PRODUCED IDENTIFICATION: TYPE OF IDENTIFICATION
FL Driver's License_____ or Other ________

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Notary Signature Notary Stamp