

MEDICAL RELEASE FORM

I, _____ (Parent/Guardian's Name) hereby give permission for any emergency medical attention to be administered to my child _____ (Child's Name) In the event of accident, injury, sickness, etc., under the direction of the person(s) listed below, until such time as I may be contacted. I also assume responsibility for the payment of any such treatment. This release is effective for the period of one year from the date given below.

ADDRESS:

HOME PHONE:

INSURANCE COMP:

POLICY NUMBER:

In case I cannot be reached, any of the following persons is designated to act on my behalf.

* Instructor: _____

* Dean: Walter Montgomery _____

PHYSICIAN: _____

ADDRESS: _____

PHONE: _____

KNOWN ALLERGIES: _____

SIGNATURE (PARENT/GUARDIAN): _____

DATE: _____