HEIGHTS CUMBERLAND PRESBYTERIAN CHURCH
MEDICAL RELEASE FORM

Name of Child/ Youth_____

Male_____ Female_____ Age_____ Birthdate_____

Family Physician_____ Physician's Phone_____

Preferred Hospital_____

Family Medical Insurance Company_____

Group #_____ Policy #_____

List any Allergies

To Medicines_____

To foods, bee stings, plants, etc_____

_____

I **do/ do not** (circle one) give permission for my child to be given over-the-counter medication (i.e. Tylenol, Ibuprophen, Benadryl, etc.)

Known Medical conditions or concerns (i.e. asthma, seizures, fainting, etc)_____

_____

Additional instructions and/ or information_____

_____

I, hereby, authorize the performance of any medical or surgical procedures under local or general anesthesia that may be advised by the attending physician of my child while patient of any U.S. hospital. I respectfully request the use of any of the hospital's services or facilities that may be regarded as necessary or beneficial in the performance of said procedure. I agree to hold the doctors and hospital harmless from any liability in the treatment or admission of my above named child.

Let this be your authority to treat and admit my child until I am able to arrive at your hospital and formally sign the necessary papers. It is understood that this authorization is given in advance of any specific diagnosis or emergency treatment being rendered.

Signature of Parent/ Guardian_____ Date_____