Trinity Christian School
Medical Release Form

Date: _____

Student's Name_____

Father/Guardian_____ Contact #'s_____

Mother/Guardian_____ Contact #'s_____

Name of Doctor_____ Phone #_____

Name of Dentist_____ Phone #_____

Insurance Company _____Policy #_____

Policy Holder_____Policy Holder Social Security # _____

Policy Holder employed by _____

Address of Insurance Company _____

List any medical issues that an emergency worker should know before medical treatment is administered (asthma, diabetes, epilepsy, allergies, etc). Include medications student takes regularly and allergies to medications. Please note any additional pertinent information on the reverse if necessary.

_____

_____

_____

Persons other than parents who can be contacted in case of an emergency (people we can contact at a moment's notice if necessary):

_____	_____	
Name/relationship	Phone #1	Phone #2
_____	_____	
Name/relationship	Phone #1	Phone #2

In case of a medical emergency, we the parents hereby give permission to Trinity Christian School personnel to call upon emergency medical services and allow any and all emergency medical treatment as medical personnel see fit. I accept responsibility for the cost of any and all medical treatment that might be needed should a medical emergency arise.

_____	_____
Parent or Guardian's Signature	Date
_____	_____
Parent or Guardian's Signature	Date