

MEDICAL RELEASE FORM & INFORMATION**Emergency Contact Information**

Child's Name: _____ Gender: M / F Birth Date: _____

Parent/Guardian's Name: _____

Phone Numbers: (Home: _____) (Cell: _____) (Work: _____)

Emergency Contact(s) in the event the parent/guardian cannot be reached:

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Basic Medical & Insurance Information

Doctor: _____ Phone: _____

Preferred Hospital: _____

Insurance Carrier: _____ Policy Holder: _____

Group Name & Number: _____ Policy #: _____

I have advised Portland Christian Center that the above-listed Child has the following special medical needs:

O Medical diagnosis of: _____

O Allergies to _____

O Life-threatening reaction to this allergy is likely/probable*

O Moderate to severe (but not a life-threatening) reaction to this allergy is likely/probable

O Asthma

O Other: _____

List allergies & medication(s) taken for control: _____

List all medications that student may be taking: _____

Dosage: _____

I, the parent or guardian of the child named above, give my permission for any emergency medical or dental treatment in the event that I cannot be reached. I also give permission for release of non-prescription medications when needed.

Parent/Guardian Signature (Required if under age 18)_____
Date

* Note- If you indicate that a life-threatening reaction is likely, we will call 911 if symptoms appear. EMT costs will be charged to you.