Flint First Wesleyan Student Ministries <u>Medical Release Form</u>

Event Name:		D	ate(s):		•
Name:				Age	Birthday
	FIRST				
Year in school				0	7 '
		-			Zip
Phone					
Medical insurance company					
Mother's name					Work
Father's name			-		Work
Emergency contact			Phone: Hom	e	Work
Physician			_Office phone		
Dentist			_Office phone		
	if any action of clude names of	protection is re medications ar or this student.	quired on accound dosages that land	nt thereof. S must be take	age with details:
Please Describe:					
2. Does your child suffer fro ☐ asthma ☐ frequently upset This consent form gives pe	□ epilepsy stomach □ rmission to seel	y / seizure disoro physical handic k whatever med	der cap cal attention is o	heart troubl	le □ diabetes
Church and its staff of any	iability against	personal losses	of named child.		
and requires the attention of licensed physician. In the exchurch, I/we agree to hold the giving of such consent. care should the cost of that	f a doctor, I/we vent treatment is such person freat/We also acknowed to medical care notion provided a	consent to any is required from e and harmless owledge that we ot be reimburse	reasonable med a physician and of any claims, d will be ultimate d by the health i	ical treatmer /or hospital pemands, or s ly responsibl nsurance pro	ne event that he/she is injured on the as deemed necessary by a personnel designated by the suits for damages arising from the for the cost of any medical povider. Further, I/we affirm that the best of my/our knowledge, still
Parent/guardian signature:					Date:
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