

**CHRISTIAN FELLOWSHIP SCHOOL  
MEDICAL RELEASE FORM**

**Medical Consent**

Student's Name \_\_\_\_\_ Birth Date \_\_\_\_\_

Student's Medical Allergies:

\_\_\_\_\_  
\_\_\_\_\_

Regular Medical Conditions: \_\_\_\_\_

Specific Medical Condition: \_\_\_\_\_

Home Address: \_\_\_\_\_ Home Phone \_\_\_\_\_

If a medical emergency should arise, the caregiver will first attempt to contact the parent. If a parent cannot be reached, the caregiver will contact the person you have given us permission to notify in the case of an emergency.

If the emergency is such that immediate hospital attention is necessary, we will either transport the child to the emergency room to a nearby hospital or call 911, depending on the seriousness of the emergency. If emergency medical care is deemed necessary and you cannot be reached immediately, you will authorize Christian Fellowship School administrative staff to act on your behalf in granting permission for your child to receive emergency care or treatment.

I, \_\_\_\_\_, the parent or legal guardian of my child \_\_\_\_\_,

Whose date of birth is \_\_\_\_\_, give my permission to Christian Fellowship School administrative staff to act in my behalf if emergency medical attention is needed.

Hospital Insurance      Yes \_\_\_\_\_      No \_\_\_\_\_      Emergency Contacts:

Name of Insurance Company \_\_\_\_\_ Name \_\_\_\_\_

Policy Number \_\_\_\_\_ Relationship \_\_\_\_\_

Policy Holder \_\_\_\_\_ Phone \_\_\_\_\_

Policy Holder Social Security Number \_\_\_\_\_

Family doctor or Pediatrician's Name \_\_\_\_\_

Mother Signature \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

Father's Signatue \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_