

_____ **Presbyterian Church**

_____, FL _____

Office #: _____

Medical Release/Liability Disclaimer Form

January 20____ to January 20____

Today's Date _____

Participant's Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

Age: _____ Grade _____

Parent(s)/Guardian(s) Names and Phone Number:

Name: _____ Phone: _____ Cell# _____

Name: _____ Phone: _____ Cell# _____

The undersigned does hereby give permission for _____
to attend and participate in activities sponsored by _____ Presbyterian Church.

We (I) authorize and adult, in whose case the minor or myself has been entrusted, to consent to any X-ray examination, anesthetic, medical, surgical, or dental diagnosis for treatment, and hospital care, to be rendered to the minor or myself under the general or special supervision and on the advise of any physician or dentist licensed under the provisions of the Medical Practice Act on the medical staff of a licensed hospital; whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

The undersigned shall be liable and agree(s) to pay all cost and expenses incurred in connection with such medical and dental service rendered to the aforementioned child or myself to this authorization.

Should it be necessary for my child or myself to return home due to medical reasons or otherwise, the undersigned shall assume all transportation cost.

The undersigned does also hereby give permission for my child or myself to ride in any vehicle designated by the adult in whose care my child or myself has been entrusted while attending and participating in activities sponsored by _____ Presbyterian Church.

Name of Family Physician: _____ Phone: _____

Date of Last Tetanus Immunization: _____

Insurance Company: _____ Policy #: _____

Emergency Contact Person: _____ **Phone:** _____

Please fill out the reverse side

Allergies: If you have any serious allergy problems, or if you are allergic to any specific medications, please list them.

Medical Problems: If you have any medical problems or physical conditions of any kind, please list them and explain below.

Medication: If you are currently taking any form of medication(s), please list their names below.

Signatures:

Participant

Mother

Father

Legal Guardian

Personally known to me or shown ID# _____, IN WHITNESS
WHEREOF, I have hereunto set my hand and official seal, at _____ in _____
County, State of Florida this _____ day of _____ 20_____.

Notary Public

Commission Expires

***Please attach a copy of your insurance card.**