

**COMMUNITY CHRISTIAN SCHOOL  
MEDICAL RELEASE FORM**

To: Emergency Personnel

Date: \_\_\_\_\_

I hereby give my consent to any medical personnel to administer necessary treatment to my child: (please print) \_\_\_\_\_ in the event of an emergency if I cannot be contacted. I give consent for him/her to be transported by ambulance if needed.

\_\_\_\_\_  
Signature of parent or guardian

\_\_\_\_\_  
State of Florida, Pinellas County

On the \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_, before me came \_\_\_\_\_, to me known to be the individual described in and who executed the foregoing instrument and acknowledged that they executed the same.

\_\_\_\_\_  
Notary Public

**PLEASE PRINT CLEARLY & COMPLETE ENTIRE FORM**

Child's Full Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Phone: \_\_\_\_\_ DOB: \_\_\_\_\_

Allergies of Child: \_\_\_\_\_

\_\_\_\_\_  
List all medications currently taking: \_\_\_\_\_

\_\_\_\_\_  
Date of last tetanus shot: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Choice of Hospital: \_\_\_\_\_

Insurance Co. covering child: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Exp. Date \_\_\_\_\_

**EMERGENCY NUMBERS**

Father's Name: \_\_\_\_\_ Mother's Name \_\_\_\_\_

Father work: \_\_\_\_\_ Mother work: \_\_\_\_\_

Home Number: \_\_\_\_\_ Other: \_\_\_\_\_

Other than parents:

Emergency Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_