



# THE HOUSE OF HOPE PRESBYTERIAN CHURCH

## Youth Medical Release Form

Name of Child: \_\_\_\_\_

Name(s) of Parent(s) / Guardian(s): \_\_\_\_\_

\_\_\_\_\_

Phone number(s) \_\_\_\_\_

Emergency contact: other than parent):

\_\_\_\_\_

(include name and phone number)

Known allergies: \_\_\_\_\_

Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Insurance Company \_\_\_\_\_

Carrier: \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

I, the undersigned, hereby state the above to be true and accurate to the best of my knowledge, and IN CASE OF EMERGENCY, give my permission to the physician or hospital selected by the DIRECTOR to secure proper treatment, to hospitalize and to order injections, anesthesia or surgery for the above named participant.

Signed: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Date: \_\_\_\_\_