Lewinsville Presbyterian Church
Parent Medical Release Form

(This form should be completed annually.)

Child's name:_____ DOB: _____ Grade: ____

Address: _____

Home phone: _____ Cell phone: _____

Mother's name: _____ Father's name: _____

Physician's name: _____ Phone: _____

Insurance carrier: _____ Policy or ID number: _____

Insurance company phone (for treatment approvals): _____

Medications currently taken: _____

Allergies: _____

Being the parent or legal guardian of above child, I do consent to any x-ray, anesthetic, medical, surgical, or dental diagnosis or treatment that may be deemed necessary for my child. Further, I understand that all efforts will be made to contact me prior to treatment. In the event I cannot be reached in an emergency, I give permission to the activity leader to make the decisions necessary for treatment. Should there be no activity leader available, I give permission to the attending physician to treat my child. I further understand that the doctors, dentists, and other providers attending to my child will take all reasonable safety precautions during their care.

Further, as parent or legal guardian I am responsible for the health care decisions for my child and agree that my insurance plan is the primary plan to pay for the dental, medical, or hospital care or treatment that is given to my child. Any policy of the church or organization sponsoring this event will be used as the secondary coverage.

Signature of parent/guardian: _____ Date: _____

Rev. 6/05