Bethesda United Methodist Church
Medical Release Form—Page 1

Parent/Legal Guardian's Name:_______________________________
Address:____
Phone Numbers: Home ( ) __________ - ____________
Work ( ) __________ - ____________
Cell ( ) __________ - ____________
Other ( ) __________ - ____________

Children's Names	List all known medical conditions, including food allergies and/or drug allergies. In addition, include any and all over-the-counter and/or prescription drugs taken regularly.

In an emergency, please contact:______________________________
Relationship to child/children:_______________________________
Phone Numbers: Home ( ) __________ - ____________
Cell ( ) __________ - ____________
Other ( ) __________ - ____________

Or contact:____
Phone Numbers: Home ( ) __________ - ____________
Cell ( ) __________ - ____________
Other ( ) __________ - ____________

Physician's Name:_______________________________________
Address:____
Phone Number: ( ) _____________ - ________________

Dentist's Name:____
Address:____
Phone Number: ( ) _____________ - ________________

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Medical Release Form Continued—Page 2

Primary Insurance Company:_______________________________________
Phone Number: ( ) _______________ - ______________________
Billing Address:____
Policy Holders Name:____
Address:____
Relationship to Child/Children:______________________________
ID Number:____________________ Group/Policy Number:_____________

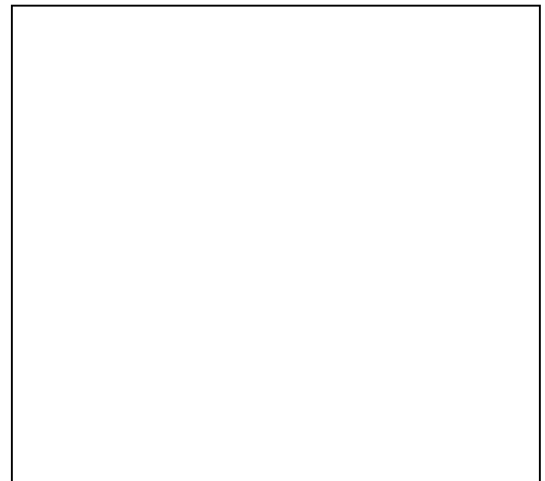
Secondary Insurance:____
Phone Number: ( ) _______________ - ______________________
Billing Address:____
Policy Holders Name:____
Address:____
Relationship to Child/Children:______________________________
ID Number:____________________ Group/Policy Number:_____________

Statement of Consent: (To be signed in the presence of a legalized notary public.)
In the event of an emergency or non-emergency situation requiring medical treatment, I, ___________________________________, hereby grant permission for any and all medical and/or dental attention to be administered to my child/children, in the event of an accidental injury or illness, until such time as I can be contacted. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel.

Parent/Legal Guardian Signature:_____________________________________
Date:____

Notarization:
On this ____________ day of ________________________, ____________,
(Date) (Month) (Year)
_______________________________________, personally appeared before
(Name of parent /legal guardian)
me in ______________________________ County (in the state of ________________)
and, in my presence, signed this medical release form.
Name of Notary Official:______________________
Signature:____________________________________
Commission Expires:__________________________

Site for Notary Stamp



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