

**MEDICAL RELEASE FORM**

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_

Birth Date \_\_\_\_\_ Home Phone # \_\_\_\_\_

Parent / Guardian's Name \_\_\_\_\_ Work Phone # \_\_\_\_\_

Work Address \_\_\_\_\_

\*In the event that parent cannot be reached, who should be contacted in an emergency?

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

\*\*In the event that a parent / guardian or emergency contact cannot be reached, the adult advisors of Trinity Lutheran Church have my permission to take appropriate emergency medical action for my son or daughter, listed above.

**Signature of Parent or Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

Any known allergies  
\_\_\_\_\_  
\_\_\_\_\_

Medical Problems  
\_\_\_\_\_  
\_\_\_\_\_

Special Instructions and Current Medications  
\_\_\_\_\_  
\_\_\_\_\_

**INSURANCE VERIFICATION**

My son/daughter is adequately covered with accident and medical insurance under policies I already carry. The following information is the correct information to be used, if medical treatment for my son/daughter is necessary.

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

Claims Address \_\_\_\_\_

Name of Company or Individual Providing Insurance \_\_\_\_\_

Policy Number (include Member and Group Number If Applicable)  
\_\_\_\_\_

**Signature of Parent or Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_