

# Friday School Medical Release

2008-2009 School Year

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

Parent to Notify: \_\_\_\_\_

Emergency contact person other than parent: \_\_\_\_\_

In the event of an emergency where medical treatment is required I give my permission to the Woodside Baptist School Staff, Sponsors or Teachers to obtain the services of a licensed physician.

For decisions made in my absence we will not hold Woodside Baptist School, Staff, Sponsors or Teachers responsible for any accident or medical expenses.

Comments or medical restrictions or information:

\_\_\_\_\_  
\_\_\_\_\_

Any medications currently being taken: \_\_\_\_\_

Medical Insurance Information: \_\_\_\_\_

Any allergies or sensitivities to over the counter or prescription drugs: \_\_\_\_\_

\_\_\_\_\_

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

**(Parent or Guardian)**