

Church of the Covenant United Methodist Church

MEDICAL RELEASE FORM

Remit to: Youth Ministry Department, Way of the Covenant United Methodist Church 300 East Martial Avenue, Lafayette, LA 70508
Office Phone: 337-981-2088 Youth Ministry Department Email Address: youth@covenantum.org Church Website: www.covenantum.org

As the parent/legal guardian of _____, I request that in my absence the above-named minor be admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the above-named minor.

Date of Birth _____ **Date of last Tetanus Booster** _____
Known allergies including any allergies to medicine (Continue on back of form if needed).

Any other medical problems which should be noted (Continue on back of form if needed).

Name of Parent/Guardian _____

Address _____

Home Phone _____ Cell Phone _____

Person responsible for charges (if different from above) _____

Address _____

Home Phone _____ Cell Phone _____

Person to notify if parent/guardian is unavailable _____

Home Phone _____ Cell Phone _____

Family Physician _____ **Phone** _____

Insurance Carrier _____

Policy Number _____

Signature of Parent _____ **Date** _____

Signature of Witness _____ **Date** _____