Medical Release Form
FAITH Homeschoolers

Name____

Address____________________________________City______________________

Home Phone________________________ Age_______ Birthdate _______________

Authorization To Treat A Minor

In the event I cannot be reached in an emergency, I (we) the undersigned parent, parents or legal guardian of ___________________________ do hereby authorize the person or persons representing **FAITH Homeschoolers** as agents for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment an emergency hospital care which is deemed advisable by, and is to be rendered under the general or specific supervision of any member of the medical staff and emergency room staff licensed under the provision of the Medicine Practice Act and on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office or said hospital.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care required but is given to provide authority and power on the part of aforesaid agents to give specific consent to any and all such diagnosis, treatment and hospital care which the aforementioned physician in the exercise of his best judgment may deem advisable. This authorization is to be effective until it is revoked in writing to said agent. A photocopy of this consent is valid and may be used in place of the original.

_____________________________________ _______________________
Signature of Father, Mother or Legal Guardian Date

__________________________________ Work Phone_________________ Cell Phone_________________
Print Father's Full Name

____________________________________ Work Phone_________________ Cell Phone__________________
Print Mother's Full Name

Doctor____ Phone_________________________________

Medical Insurance__________________________________ Subscriber______________________________

Subscriber #_______________________________________ Group #_______________________________

Allergies/Medical
Problems____

Date of Last Tetanus Shot______________________________

Current
Medications____