AUTHORIZATION FOR MEDICAL RELEASE

Complete this form and bring it with you to the event. You can also email a scanned copy to Joy Owensby, Missioner for Christian Formation: jowensby@diocesewla.org.

Name of Participant_____

Name of Parent or Guardian_____

Address_____

Home phone_____

Mother's cell phone_____ Mother's work phone_____

Father's cell phone_____ Father's work phone_____

Guardian's cell phone_____ Guardian's work phone_____

Emergency contact information (**someone other than parent or guardian**):

Name_____

Address_____

Home phone_____ Cell phone_____ Work phone_____

Name of participant's physician_____

Physician's address_____

Physician's phone number_____

Participant's health insurance provider_____

Policyholder's name_____Policy number_____

Please list any allergies your child has, medications taken on a regular basis, and/or other health concerns that we should be aware of.

_____

_____

I, the undersigned parent/guardian of _____, hereby give my authorization and permission to any physician, emergency medical technician, nurse, hospital, and/or other medical personnel to perform any emergency medical examination, diagnosis, and/or treatment that may be needed by my child.

_____ _____

Date **Parent or Guardian Signature**