



## MEDICAL RELEASE FORM

I, \_\_\_\_\_ (Parent/Guardian's Name), hereby give permission for any and all medical attention to be administered to my child, \_\_\_\_\_ (Child's Full Name), age \_\_\_\_\_ in the event of accident, injury, sickness, etc., under the direction of the person(s) listed below, until such time as I may be contacted. I also assume the full responsibility for the payment of any and all expenses incurred in connection with such treatment. The release is effective for the Children of the Confederacy \_\_\_\_\_ Annual General Convention held in \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_, 20\_\_\_\_, including travel to and from the Convention.

### Parent/Guardian Information:

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Fax Number: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

### Insurance Information:

Company: \_\_\_\_\_ Policy/Contract Number: \_\_\_\_\_

Group Number: \_\_\_\_\_ Telephone: \_\_\_\_\_

### Physician's Information:

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

### Medical Conditions:

Known allergies: \_\_\_\_\_

Medical conditions: \_\_\_\_\_

Special needs: \_\_\_\_\_

Medications being taken: \_\_\_\_\_

If I cannot be reached, any of the following persons are designated to act on my behalf:

Name: \_\_\_\_\_ Title: \_\_\_\_\_

### Consent for medical treatment (minor):

As the parent/legal guardian of the above named child, I hereby give my consent for emergency medical care prescribed by a duly licensed hospital, Doctor of Medicine or Doctor of Dentistry. This care may be given under whatever conditions are necessary to preserve the life, limb or well-being of my dependent.

Signature (Parent/Guardian): \_\_\_\_\_ Date: \_\_\_\_\_

Witness (signature): \_\_\_\_\_ Date: \_\_\_\_\_

*Please provide a copy of your insurance card (both front and back) and return with this form.*