MEDICAL RELEASE FORM

for school year of ____ through ____

Holy Cross Lutheran Church
1020 Mocho Street
Livermore, CA 94550
(925) 447-8840

I (we), the undersigned parent(s) or guardian(s) of _______________________, a minor, do hereby authorize adult workers of Holy Cross Lutheran Church, Livermore, as agent(s) for the undersigned, to consent to any medical or surgical care deemed advisable by any physican or surgeon licensed under the provisions of the Medical Practive Act on the medical staff of any hospital.

Parent/Guardian Name (Print)______________________________________

Parent/Guardian Signature ___________________ Date ______________

Address_______________________________ City _______________

Emergency Phone #: Home (____)___________ Work (____)__________

Health Insurance Company ______________________________________

Policy or Group # ____________________ Phone # (____)___________

If parent/guardian is not available in an emergency, contact:

Name ____________________________ Phone # (____)___________

Please list any allergies. Include medications, foods, etc.

Does your child have any medical or special needs, including medications currently being used:

No______ Yes______ If Yes, Please Explain:

Doctor's Name _______________________ Phone # (____)___________

Dentist's Name _______________________ Phone # (____)___________

Date of last tetnus shot __________________Birth Date ________________