

MEDICAL RELEASE SECTION

In case of emergency, if my family physician can not be reached, I hereby authorize that my child, _____, be treated by another qualified physician.

FAMILY PHYSICIAN: _____

PHONE NUMBER: _____

LIST ANY MEDICATIONS TAKEN BY CANDIDATE: _____

MEDICAL PROBLEMS: _____

ALLERGIES: _____

OTHER SPECIAL NEEDS: _____

CONTACT INFORMATION

Name of Mother _____ Stepfather _____

Home Phone Number _____

Work Phone Number _____

Cell Phone Number _____

E-mail address _____

Name of Father _____ Stepmother _____

Home Phone Number _____

Work Phone Number _____

Cell Phone Number _____

E-mail address _____

Emergency Contact Name _____

Relationship to Candidate _____

Home Phone Number _____

Work Phone Number _____

Cell Phone Number _____

PARENT/GUARDIAN

AUTHORIZATION: _____ DATE: _____