### MEDICAL RELEASE FORM

This form is used to record parental permission for medical and surgical treatment in case medical concerns during the 2018/2019 Micah Center Programs and associated field trips

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| We, the undersigned as the parents and legal guardians of  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Print Student's Name  hereby consent to any and all medical and surgical treatments, including anesthesia and operations which may be deemed advisable by any qualified physician selected by agents or officials of the Micah Center of Pinellas County Inc. The intention thereof is to grant authority to administer and to perform all and singularly any examinations, treatments, anesthetic, operations and diagnostic procedures which may now or during the course of the patient's care, be deemed advisable or necessary by any qualified physician. Witness of our consent and agreement to the matters stated above, we have subscribed our signatures below.  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Parent/Guardian Signature Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Parent/Guardian Signature Date STATE OF FLORIDA, COUNTY OF  SUBSCRIBED and sworn to before me, a Notary Public, this day of ,20 .  Notary |
| Medical Insurance Company Policy # Student's Address Phone: Date of Birth  Father Home Phone: Business Business Phone: Mother Home Phone: Business Business Phone: Family Physician's Name Phone: Address City State NOTE: In the event of an emergency medical situation, even with the form, the chaperone will attempt first to contact the student's parent/guardian. |
| **Disposition**  Copy to office  Date  Original is retained by MICAH CENTER and COPY taken with the child if medical care is needed. |
| Health Insurance 🗖yes🗖no  Does child have a disability? (🗖yes🗖no)  If yes please describe disability in detail:  Medical allergies:  Please describe in detail (all “food allergies” trigger rashes, shortness of breath and Anaphylaxis shock. A dislike of a particular food is not an allergy. Please list allergies identified by a physician. No allergies listed will mean that no dietary alternatives will be offered to the child.) |