Medical Release Form

Spring Vale Christian School

Personal Information

Students Name: _____ Date of Birth: _____
First Middle Last

Address: _____
Street City State Zip

Phone: _____ Email: _____

Students S. S. Number: _____

Medical Insurance Information

Provide the following information about your insurance provider

Does the student have medical insurance? Yes / No
** If yes, provide the following information and a copy of the students insurance card.*

Insurance Provider: _____

Policy Number: _____ Phone Number: _____

Address: _____
Street City State Zip

Is the students medical insurance provided by their parent or legal guardians employer? Yes / No
** If yes, pleas provide the following information about your employer.*

Name of Employer: _____

Phone Number: _____ Email: _____

Address: _____
Street City State Zip

Name of Insured: _____ Insured's S. S. Number: _____

Emergency Contacts

In case of a medical emergency, if the parent/legal guardian cannot be reached, please contact the following people:

Emergency Contact 1

Name: _____

Phone: _____

Relationship to Applicant:_____

Emergency Contact 1

Name: _____

Phone: _____

Relationship to Applicant: _____

Consent for Medical Treatment

I/we _____, the undersigned parent(s) and/or legal guardian(s) of _____ do hereby give permission and authorize Spring Vale Christian School and its staff to provide over the counter medication as needed for common ailments and seek any emergency medical and/or surgical treatment deemed necessary in the judgment of the treating physician. I/we also consent to and authorize McLaren Family Care Center and/or Memorial Hospital and it's staff and/or legally qualified medical providers to administer and perform any emergency medical and/or surgical treatment deemed necessary in the judgment of the treating physician. I/we further certify that no guarantee or assurance will be made as to the outcome of such treatment. I/we understand that reasonable effort will be made by Spring Vale Christian School and/or the treating physician to contact me/us before emergency medical treatment and/or surgery is performed.

Signature: _____ Date: _____
Signature of Legal Guardian

Signature: _____ Date: _____
Signature of Spouse

Notarization

Subscribed and sworn before me this _____ day of _____, 20_____.

Signature of Notary Public: _____

My commission expires: _____

Place Notary Seal Here