

Medical Release Form

Tri-State Fellowship Student Ministries
13153 Cearfoss Pike, Hagerstown, MD 21740
(301) 790-1774 Fax (301) 790-1442
e-mail tsf@tristatefellowship.org

Student 1: _____ Date of Birth: _____ Grade _____

Student 2: _____ Date of Birth: _____ Grade _____

Student 3: _____ Date of Birth: _____ Grade _____

Parents' Name(s): _____

Address: _____ Home Phone: _____

_____ Cell/Work Phone: _____

Cell/Work Phone: _____

Medical Information

Allergies, current medications, limitations and/or handicaps, etc.:

Student 1: _____

Student 2: _____

Student 3: _____

Family Physician/Practice: _____

Family Physician/Practice Phone: _____

Medical Insurance Co.: _____ Policy #: _____

Name on the policy: _____

I hereby, for myself, my heirs, executors, and administrators, waive and release any and all rights and claims for damages that I may have against the above-named organization and/or individuals and its agents, employees, representatives, successors and assigns for any and all injuries suffered by myself or my child that arise out of a program, activity, or sport sponsored by Tri-State Fellowship and the individuals responsible for such.

In the event of an emergency, I hereby authorize an adult leader of this activity, as agent for me, to consent to any X-ray examination, medical, dental, or surgical diagnosis, treatment, and hospital care advised and supervised by a physician, surgeon, or dentist (as appropriate) licensed to practice under the laws of the state where the services are rendered, either at a doctor's office or in any hospital. I expect to be contacted as soon as possible.

Signature of parent or guardian (or student if over 18): _____

Date: _____