

MEDICAL RELEASE

(for Group Trips Sponsored by Fairview Heights Church of Christ)

Name of Student Participant _____

Address _____

City _____ State _____ Zip _____

Date of Birth _____ Phone _____

Emergency Contact Person _____

Emergency Contact Phone _____

Name of Insurance Company _____

Policy # _____

Policy Holder's Name _____

Claims Address _____

Physician's Name _____ Phone _____

Please list any medical allergies, medications being taken, medical problems, or other pertinent information _____

I understand that, in the event medical treatment is required, every effort will be made to contact me. However, if I cannot be reached, I give my permission to Fairview Heights Church of Christ or an adult sponsor to secure necessary emergency care.

Signed _____ Date _____

(Parent or legal guardian)