Parkview Christian Childcare Center

MEDICAL RELEASE FORM

As the parent/guardian of _____, I request that, in my absence, the staff of PARKVIEW CHRISTIAN CHILDCARE CENTER be hereby granted authorization to have the above child admitted to any hospital or medical facility for diagnosis and treatment. I request and authorize physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors or Dentistry or others such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment of the above minor. I have not been given a guarantee as to the results of examination or treatment. I also assume the financial responsibility for any such treatment.

Birth Date of Child _____ / _____ / _____ Date of last Tetanus Booster ____ / ____ / ____

Please list any allergies/medical problems, including those requiring maintenance medications. (i.e. Diabetic, Asthma, Seizure Disorder)

Medical Diagnosis	Medicine	Dosage	Frequency of Dosage

*The purpose of the above listed information is to ensure that medical personnel have details of any medical problems that may interfere with or alter treatment.

Any other medical problems that should be noted _____

Hospital or Clinic _____ Phone # _____

Family Physician _____ Phone # _____

Insurance Carrier _____ Policy Number _____

Name of Parent/Guardian _____

Address _____

City/State/Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Person responsible for charges (if different than above) _____

Address _____

City/State/Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Person to notify if parent/guardian is unavailable _____

Home Phone _____ Work Phone _____ Cell Phone _____

Signature of Parent/Guardian _____ **Date** _____