

Walker W.E.E. Care Emergency Release Form

I give my permission for WALKER W.E.E. CARE, Walker Baptist Church, 1350 West Main Street, Franklin, Tennessee 37064 to obtain the necessary medical attention needed for my child, _____, while he/she is in the care of the above program and its representatives.

I give my permission for my child to be treated at Williamson Medical Center.

Date: _____

Parent's signature: _____

Physician Information

Primary Physician's Name: _____

Physician's Phone Number: _____

Medical Group Affiliation: _____
(Clinic/hospital/etc.)

Hospital of Choice: _____

Insurance Information

Company Name: _____

Group Number: _____ ID Number: _____