Wisdom's Way
Medical Release Form

School Year: _____ **Child(ren) Information**

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

Name: _____ Date of Birth: _____

_____

Name of Parents

_____ _____ _____ _____

Address **City** **State** **Zip code**

_____ _____ _____

E-Mail Address (Used for communication.) **Home Phone** **Cell Phone**

I give permission for my above named child(ren) to attend Wisdom's Way Cooperative located at Faith Church, Milford, OH, for the _____school year. I release Wisdom's Way Cooperative, its' staff and sponsors, and Faith Church, its' staff and sponsors, from responsibility and liability for any injury or illness that my child may sustain during this activity. In the event of a medical emergency, I authorize the leadership of Wisdom's Way Cooperative as agent for me, to consent to any emergency medical treatment such as: 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 laws of the state where the services are rendered, either at a doctor's office or any hospital. I expect to be contacted as soon as possible.

PARENT MUST COMPLETE THE MEDICAL INFORMATION

Medical Insurance Company: _____ Policy #_____

Member's Name: _____

Family Doctor Name: _____ Phone #: _____

NOTE: Allergies must be listed for each child on the second page.

Parent's Initials: _____

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Emergency Phone Numbers:

Name	Relationship to Child	Phone Number

Child's Medical Information

Please list any food or drug allergies and any medication your child is currently taking. This information will be kept confidential and would only be used in case of an emergency. **The food allergies listed will be shared with your child)ren's teachers to ensure classes with food and/or beverages are aware of these concerns.** Attach additional sheets if necessary.

Child:	**Food Allergies:**
Medications:	**Drug Allergies:**
Please indicate any other medical condition or special needs below:	

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_____ _____

Signature of Parent or Legal Guardian **Date**