MEDICAL RELEASE FORM

First United Methodist Church
109 Gayle Avenue S.W. P. O. Box 1025
Jacksonville, AL 36265
(256) 435-6021 Fax (256) 435-6262

Student's Name: ________________________________ **Social Security #** ______________
(Last) (First) (MI)

Student's Date of Birth: ______________________________
(Month/Day/Year)

Mother's Name: ________________________________ **Social Security #** ______________
(Last) (First) (Maiden)

Father's Name: ________________________________ **Social Security #** ______________
(Last) (First) (MI)

Address: ____

City: __________________________ **State:** ____________________ **Zip:** __________

Home Phone: __________________________ **Work Phone:** __________________________

Other Emergency Phone: ____

Insurance Company: ____

Insurance Number: Group - ____________________ **Individual -** ____________________

Address of Insurance Company: ____

Allergies or Other Notable Health Conditions: _____________________________________
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____

Current Medications: ____
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If a medical emergency should arise and I (parent or guardian) cannot be reached, I hereby give my permission for my child to be treated as is necessary for their best interest. I further give permission for any necessary decisions that must be made pertaining to said treatment to any designated adult responsible for the care and safety of the children and/or youth of First United Methodist Church of Jacksonville, Alabama.

Date: ____________ **Signature:** ____

Notary: ________________________________ **Commission Expires:** ______________