SPIRIT ACADEMY
Medical Release Form 2010-2011

Student's Name: _____ Grade: _____

Birth Date: _____ Date of last Tetanus booster: _____

Are there any medical or health related problems? ____Yes ____ No

If yes, what are they and are there any restrictions? _____

_____

_____

Are there any food allergies? ____Yes ____No

If yes, what are they and are there any restrictions? _____

_____

Can we give your student Tylenol? ____Yes ____No Dosage? _____ _____

I (we) the undersigned parent(s) or guardian(s) of the minor child named above, do hereby authorize and consent to any x-ray, examination, anesthetic, medical or surgical diagnosis and treatment and emergency hospital care which is deemed advisable by and is to be rendered under the general or specific supervision of any member of the medical staff and/or the emergency room staff licensed under the provisions of the Medical Practice Act and/or the staff of any acute general hospital or emergency clinic holding a current license to operate a hospital or emergency clinic, from the state of California, Department of Health Services. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority to render care which the aforementioned physician, in the exercise of his/her best judgment, may deem advisable. It is understood that every effort shall be made to contact the undersigned parent(s) or guardian(s) prior to the rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached. This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. The undersigned also assumes the responsibility for any and all costs associated or connected with such treatment and hereby releases all leaders, associates, members, or others acting for or on behalf of SPIRIT ACADEMY from any and all liability and agrees to hold harmless all of the above.

This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under any emergency circumstances in my absence, and shall be valid until revoked in writing.

Dated this _____ day of _____ , _____

_____ _____ ( ) _____
Father/Guardian Signature Please Print Name Daytime Phone

_____ _____ ( ) _____
Mother/Guardian Signature Please Print Name Daytime Phone

Alternative Emergency Contact _____ ( ) _____
Please Print Name Daytime Phone

Physician's Name _____ ( ) _____
Daytime Phone

Insurance Company _____ Policy Number _____