Faith
PREPARATORY SCHOOL

Medical Release Authorization
** MUST BE NOTARIZED **

Name of child/youth: _____Age:____

Parent/ Guardian: _____

Address: _____ City:_____ Zip:_____

Home Phone Number: _____Cell Number: _____

As the parent (or legal guardian) of: _____
I understand that my child will be participating in a number of activities for the school year _____, which carry with them a certain degree of risk. I consent for my child to participate in these activities.

Please indicate any restrictions on your child's activities:

_____ I represent that my child is physically fit and has the necessary skills to safely participate in these activities.

_____ I represent that my child has restrictions on the following particular activities:

_____

MEDICAL TREATMENT AUTHORIZATION
It is my understanding that the school will attempt to notify me in care of a medical emergency involving my child. If they cannot reach me, then I authorize the school to hire a doctor or health-care professional, and I give my permission to the doctor or other health-care professional, to provide the medical services he or she may deem necessary. I will pay for any medical expenses so incurred.
I will notify the school if I feel there are any health considerations that would prevent my child participation in any of the activities listed above.

Allergies or other health considerations:_____

Insurance Company: _____Policy/Group #_____

Signature of Parent or Guardian: _____

Notary Stamp/Seal, Date and Signature: _____