

Release Form

Please print below.

**** Please attach a copy of insurance card and immunization records.**

INFORMATION

Name: _____ Date of Birth: _____

Parents Names: _____

Home Address
City/State/Zip: _____

Home Phone: _____ Work: _____ Emergency: _____

Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Social Security Number: (Optional) _____

MEDICAL HISTORY

Please list any medical problems and medications:

Allergies: _____

Past surgeries: _____

Date of tetanus shot or booster: _____

List any drug allergies: _____

List any food allergies: _____

Please check any condition that would be important for the physician to know about:

Allergy Asthma Diabetes Epilepsy Hearing Heart
Vision Other: Explanation of other: _____

Note any disabilities: _____

Doctor's name: _____ Phone: _____

Address
City/State/Zip: _____

Dentist's name: _____ Phone: _____

Address
City/State/Zip: _____

MEDICAL INSURANCE INFORMATION

Insurance Company: _____

Address
City/State/Zip: _____

Phone Number: _____ Policy Number: _____

Group Number: _____ Insurance Card Holder: _____

Card Holder's Social Security Number: _____

EMERGENCY CONTACT INFORMATION

1. Name: _____ Relationship: _____ Phone #'s: _____

2. Name: _____ Relationship: _____ Phone #'s: _____

TREATMENT

In case of emergency, I hereby give permission to the physician selected by the North Oak Community Church staff and or assigned personnel to hospitalize, secure treatment for, and to order injection, anesthesia and/or surgery for the person named above.

Signature: _____

**** Please attach a copy of insurance card and immunization records.**

** Please notify North Oak Community Church of changes in insurance and other important information.