



## Youth Medical Release Form continued

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Date of last tetanus: \_\_\_\_\_

Do you have medical/dental insurance for your Youth? \_\_\_\_\_

<b>Medical</b>	<b>Dental</b>
Primary Insurer's Name: _____	Primary Insurer's Name: _____
SSN/ID Number: _____	SSN/ID Number: _____
Primary Insurer's DOB: _____	Primary Insurer's DOB: _____
Insurance Co.: _____	Insurance Co.: _____
Policy/Group Number: _____	Policy/Group Number: _____
Call in Phone Number: _____	Call in Phone Number: _____

**Consent:**

I/we the undersigned, parent(s)/legal guardian(s) of \_\_\_\_\_, do hereby consent to x-ray exam, anesthetic, medical, dental, or surgical diagnosis of treatment, and hospital service that may be rendered to said minor, under the general specific instructions of \_\_\_\_\_ (Youth's physician) or if unavailable, on-call physicians at an Accredited Health Care Facility.

It is understood that this consent is given in advance of any specific diagnosis and is given to encourage those persons who have temporary custody of my child during my absence, and/or said physician to exercise their best judgment as to the requirements of such diagnosis or surgical, medical, or dental treatment.

This consent shall remain effective for all Youth outings at Shadow Rock United Church of Christ from September 12th, 2004 through June 30, 2005. I understand that any and all medical or dental expenses incurred during this emergency are my responsibility.

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

