MEDICAL RELEASE FORM

St. Spyridon's Greek Orthodox Church- San Diego, CA.

Personal Information

Son/daughter's name ________________ Age _____________ Birth date ___________

Address ____________________ City ________________ Zip ________

Parent or Guardian ___________________________ Phone(s)HM-__________Cell-____________

Person (other than above) to call in case of an emergency:

Name: ______________________________ Phone(s) ____________________________________

Health Information Necessary for Proper Care and Protection

In order to assist any needed medical personnel in caring for your Child please fill out the following:

Describe any health factor that makes it advisable for your son/daughter to limit physical activity:

____

Is your child currently on any medications please
list:____

Any known allergy to medication.____

Directions for current medications____

Has a tetanus shot been given within the last five years?______

Name of family physician____

Address____Phone______________________________

If yes, Explain:____

May have aspirin if needed?________________ Aspirin substitute?______________________________

Do any foods cause allergic reaction? __________If so explain: ________________________________

If a serious emergency would arise, it might be necessary for a physician to attend to your son/daughter before the staff could get in touch with you or your designated physician. Such care can be provided only if you sign the following:

Authorization for Medical Treatment & Parent Permission

I,________________________hereby authorize that emergency medical and/or surgical care may be provided for my son/daughter __________________. I also hereby release, discharge and hold harmless St. Spyridon's Greek Orthodox Church, San Diego Ca. and not limited to Clergy, Staff, Teachers and Adult supervisors from any damage, demands, actions whatsoever in any manner arising or growing out of my son or daughter's participation in St. Spyridon's activities or programs. Except for those limitations named on this health form, I certify that ____________________________is healthy and fit to participate in this event.

Signature __________________________________**Date** _________________________

Insurance Company ___________________ Policy Number____________________________