Christian Reformed Church of St. Joseph

Medical / Photo Release Form

Date: _____

As the parent/guardian of _____, I request that in my absence the previously mentioned student(s) be admitted to any hospital or medical facility for diagnosis and treatment as the result of an accident or injury. I request and authorize physicians, dentists and staff duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and x-ray treatment for the above minor.

Birth date of Student: _____ Date of Last Tetanus Booster: _____

Known allergies of student: _____

_____

Other medical problems: _____

_____

Family Physician: _____ Phone #: _____

Insurance Carrier: _____ Group #: _____ Policy #: _____

Name of Parent/Guardian: _____

Address: _____

City/State/Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Emergency Contact: _____ Work Phone: _____

Home Phone: _____

Cell Phone: _____

Signature of Parent/Guardian: _____ Date: _____

PHOTO/VIDEO

I understand and approve that my child's picture may be taken during events and may uploaded to CRCSJ website or used in other CRCSJ material/brochures.

Signature _____ Date: _____