

Saddleback Valley Unified School District, Child Care Services  
**MEDICAL RELEASE FORM - PRESCHOOL CONNECTION 2020/2021**

Child's Name \_\_\_\_\_  
Last First M.I.

Parent or Guardian Names \_\_\_\_\_

Child's Home Address \_\_\_\_\_

Mother's Cell \_\_\_\_\_ Father's Cell \_\_\_\_\_

Mother's Work \_\_\_\_\_ Father's Work \_\_\_\_\_

Birthdate \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Teacher \_\_\_\_\_

School \_\_\_\_\_

Special Alert- Allergies \_\_\_\_\_ Epi Pen \_\_\_\_\_ Inhaler \_\_\_\_\_

Legal Documents on File (i.e. restraining order, custody, etc.) \_\_\_\_\_

Persons other than parents who are authorized to sign out child or to be called in an emergency:

Name	Residing City	Phone	Relationship
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Out of State Contact- Name \_\_\_\_\_ Phone \_\_\_\_\_

**Note: 911 will be called in an emergency**

Doctor's Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Current Medications \_\_\_\_\_

Admin. of Medicine form completed Y N (please see office staff)

Medical Conditions (i.e. allergies, epilepsy, motion sickness, etc.) \_\_\_\_\_

Hospital Preference \_\_\_\_\_

**Consent to Treat a Minor**

The above participant has my permission to engage in all program activities, except as noted by me. In the event that I cannot be reached in an emergency, I hereby give permission to the program staff to hospitalize and secure proper treatment for my child. If an ambulance needs to be called, the program staff has my permission.

Printed Name \_\_\_\_\_ Signature \_\_\_\_\_ Relationship to child \_\_\_\_\_ Date \_\_\_\_\_

*Wet signature required - Please sign after printing.*