Saddleback Valley Unified School District, Child Care Services

MEDICAL RELEASE FORM

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**______ **Grade**______ **Teacher**______________

School____

Special Alert- Allergies______________________________**Epi Pen**______ **Inhaler**______

Legal Documents on File (i.e. restraining order, custody, etc.**)**______________________

Persons <u>other than parents</u> 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.

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Printed Name **Signature** **Relationship to child** **Date**

Wet signature required - Please sign after printing.