# EMERGENCY MEDICAL INFORMATION 2010-2011

NAME OF CHILD_____ AGE_____

ADDRESS_____

CITY,STATE,ZIP_____ HOME PHONE_____

PARENTS WORK PHONE NUMBER(S)_____

OTHER THAN PARENT, IN CASE OF EMERGENCY NOTIFY

NAME_____ PHONE_____

DATE OF LAST TETANUS SHOT_____

ANY HEALTH RESTRICTIONS, ALLERGIES, OR MEDICATIONS_____

_____

_____

INSURANCE COMPANY_____ POLICY #_____

**MEDICAL RELEASE:**

In the event I cannot be reached in an emergency during a Kasilof Community Church activity for the years 2010-2011, I hereby give my permission to the physician or dentist selected by Kasilof Community Church to hospitalize, to secure proper treatment and/or order an injection, anesthesia, or surgery for my child as deemed necessary. The signature of the parent or guardian below is intended to serve as a medical release.

**PARENT OR GUARDIAN SIGNATURE**_____

DATE_____ PRINT NAME_____

RELATIONSHIP TO CHILD_____

KASILOF **COMMUNITY CHURCH**
**PO Box 57, Kasilof, AK 99610**
**(907) 262-7512**

**Include any pertinent information below or on the other side**