WOODSIDE CHAPEL
MEDICAL RELEASE FORM

Child(ren)'s Names	**Date of Birth** (mm/dd/yy)

Address _____

Home Phone # **Cell Phone #** _____

Emergency contact in case parents cannot be reached:

_____

Name Relationship to child(ren) Phone #

I GIVE PERMISSION FOR MY CHILDREN TO ATTEND AND TO PARTICIPATE IN THE ACTIVITIES AT WOODSIDE CHAPEL. IN CASE OF A MEDICAL EMERGENCY, EVERY EFFORT WILL BE MADE TO CONTACT ME. HOWEVER, IF I CANNOT BE REACHED, I GIVE MY PERMISSION TO THE STAFF AT WOODSIDE CHAPEL TO SECURE THE SERVICES OF EMERGENCY PERSONNEL/LICENSED PHYSICIANS TO PROVIDE THE NECESSARY CARE, INCLUDING ANESTHESIA, SURGERY OR HOSPITILIZATION (IF NECESSARY) FOR MY CHILDREN'S WELL BEING.

Medical Insurance Carrier: _____

Policy #: _____

Hospital: _____

Allergies / Medical Issues: _____

_____

I UNDERSTAND THAT WOODSIDE CHAPEL, THE VACATION BIBLE SCHOOL PROGRAM AND ITS STAFF ARE NOT HELD RESPONSIBLE FOR ANY MONETARY INCURRENCE FOR SAID MEDICAL TREATMENT.

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Parent's Signature Date