



Medical Release Form

Parent/Legal Guardian's Name: _____

Address: _____ City/State _____ Zip _____

Phone #: Home (_____) _____ - _____ Work (_____) _____ - _____

Cell (_____) _____ - _____ Other (_____) _____ - _____

Children's Names	List all known medical conditions (inc. food and/or drug allergies). List all over-the-counter and/or prescription drugs taken regularly.

Emergency Contact #1	Emergency Contact #2
Name: _____	Name: _____
Relationship to child: _____	Relationship to child: _____
Phone #: _____	Phone #: _____

Primary Insurance Company: _____ Policy Holder's Name: _____

Phone #: (_____) _____ - _____ ID# _____ Group# _____

In the event of an emergency or non-emergency situation requiring medical treatment, I, _____, hereby grant the permission for any and all medical attention to be administered to my child/children, until such time as I can be contacted. This permission includes, but is not limited to, the admission of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel.

Signature: _____ Date: _____

Please fax form to Myra Carlock at 731-352-6440 or mail to:
Bethel University
Attn: Myra Carlock
325 Cherry Ave.
McKenzie, TN 38201