

# MEDICAL RELEASE FORM

I, the undersigned parent or guardian of \_\_\_\_\_, a minor, do hereby authorize Indiana Bahá'í School, or its designated representative, agent(s) for the undersigned, to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. As the parent/guardian of a minor under the age of 18, I understand that this authorization enables Indiana Bahá'í School to arrange medical care for my dependant minor in the event I am unavailable.

I understand that I am responsible for payment of any and all medical expenses incurred on behalf of my dependent minor. This authorization shall remain effective from \_\_\_\_\_ [date] to \_\_\_\_\_ [date], when my child is attending the Indiana Bahá'í School.

Parent / guardian signature: \_\_\_\_\_ Date: \_\_\_\_\_

Home phone: \_\_\_\_\_ Mobile phone: \_\_\_\_\_

Medical insurance company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Family physician name and telephone: \_\_\_\_\_

In the event parent / guardian cannot be reached: \_\_\_\_\_

Emergency contact name and telephone: \_\_\_\_\_

Emergency contact name and telephone: \_\_\_\_\_

List allergies, handicaps, limiting health conditions, medications, reactions to medications