MEDICAL RELEASE FORM

I, _____, am the parent or legal guardian of _____,
Name of Parent/Guardian Name of Minor

hereinafter, “my child”, who was born on _____, _____. My child is attending and participating in activities with "Calvary United Methodist Church", located at 301 Rowe Boulevard, in the city of Annapolis, county of Anne Arundel and state of Maryland. I understand that this authorization form applies to all activities sponsored by or held at "Calvary United Methodist Church", beginning on the September 1, 2015, through September 30, 2016.

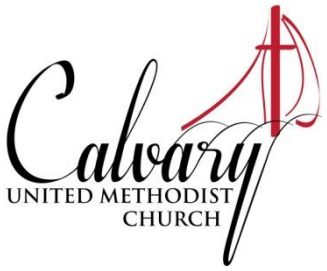
I hereby authorize the staff or agents who are 23 years of age or older, who supervise the activities sponsored by or held at "Calvary United Methodist Church" into whose care my child has been entrusted, to consent to medical care or dental care, or both, for my child. The authority granted by this authorization includes the authority to consent to any x-ray examination, anesthetic, medical, or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician and surgeon licensed under the Medical Practice Act for my child. This authority also extends to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment and hospital care by a dentist licensed under the Dental Practice Act for my child.

I further authorize the staff or agents who are 23 years of age or older, who supervise the activities sponsored by or held at "Calvary United Methodist Church" to receive physical custody of my child upon completion of any treatment, and I specifically instruct any treating health facility to surrender physical custody of my child to the staff or agents who are 23 years of age or older who supervise the activities sponsored by or held at "Calvary United Methodist Church."

It is understood that this authorization is given in advance of any special diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of the supervisor and his/her authorized designee, in the exercise his/her best judgment on what is advisable for my child’s care, upon advice of such physician, dentist, and surgeon.

Dated _____, _____ _____
Signature of Parent/Legal Guardian

MEDICAL RELEASE FORM



_____
Child's Name

_____
Parent/Guardian

_____
Address (Include House Number, Street, City, State, & Zip)

_____ _____ _____
Home phone Work phone Cell Phone

_____ _____
Additional Phone Contact Emails for Reminders or Cancellations

_____ _____
Medical/Health Insurance Provider Insurance Policy Number

_____ _____
In Case of Emergency, Notify Parent/Guardian Relationship to Minor

_____
Allergies/Allergic Reactions of My Child

_____
Medicine Taken Daily By My Child

_____
Other Information Regarding My Child's Health That A Doctor Should Know

I understand that should any of the above information including my contact information or my child's health insurance provider change, I will submit a new authorization form. I understand that this form is to be used during September 2015 – September 2016 for "Calvary United Methodist Church."

MEDICATION RELEASE:
Additionally, I give permission for "Calvary United Methodist Church" staff members, if necessary, to give my child the following medications: _____Acetaminophen _____ Ibuprofen _____Antacid _____Cough Drops

_____ _____
Parent/Legal Guardian Signature Date