

GENERAL MEDICAL INFORMATION AND RELEASE FORM

I give permission for: (Name of Student): _____
to participate in the ERUCC Trip to Franklinton Center, from January 18-20, 2014.

Address of Student: _____

Phone Number: _____

Date of Birth: _____

In case of emergency during the weekend please contact:

Name: _____

Phone Number: _____

Family Physician/pediatrician:
Name: _____

Phone Number: _____

Health Insurance Carrier: _____

Policy No. _____

Any special medical information (allergies, etc.):

In cases of medical emergency, I understand every effort will be made to contact me. In the event I cannot be reached, I hereby give permission to the physician selected by Rev. Barbara Kershner Daniel or Stephanie Pain or other leaders of the youth trip to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery for my child as named above.

(Parent's signature) _____

(Address) _____

(Date) _____