

## Diocesan Medical Release Form

Name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Parent's Work Phone \_\_\_\_\_

Church \_\_\_\_\_

Notify in Case of Emergency: \_\_\_\_\_ Phone: \_\_\_\_\_

**PARENTS:** (Application will not be accepted without parent's signature.)

I hereby release the Diocese of Central Florida and its staff from any responsibility and liability for any injury or illness that my child may sustain during this activity. In the event of an emergency, I hereby authorize an adult leader of this activity to act as agent for me to consent to any medical, dental, or surgical treatment and care deemed necessary by a licensed medical professional. I expect to be notified as soon as possible.

Parent or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent Print Name: \_\_\_\_\_

Phone (if different from above): \_\_\_\_\_

**Insurance Information:** Policy Number: \_\_\_\_\_

Company: \_\_\_\_\_ Policy in Name of: \_\_\_\_\_

Social Security Number of Policy Holder: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

In the space below please list any dietary and/or medical needs or physical limitations your child might have: