



SCCYAA Medical Release Form



Child's Name: _____ **DOB:** _____ **Grade:** _____

Parent/Guardian Name: _____ **Work/Cell Phone:** _____

Parent/Guardian Name: _____ **Work/Cell Phone:** _____

Home Address: _____ **Home Phone:** _____

Emergency Care

If I/we cannot be reached immediately in an emergency, I/we delegate full authority and temporary care of the child to the following local relatives, neighbors, or friends:

Name: _____ **Relationship to child:** _____

Address: _____ **Phone:** _____

Name: _____ **Relationship to child:** _____

Address: _____ **Phone:** _____

In case of emergency, I/we authorize the supervisor(s) to call the physician listed (or another if he/she cannot be reached) and follow his/her instructions:

Physician: _____ **Phone:** _____

Choice of Hospital: _____

I/we authorize the supervisor(s) to call an ambulance or paramedics or fire department, and to follow instructions given. The supervisor(s) does not assume any responsibility for the above emergency procedures and does not assume payment for measures taken.

****Parent/Guardian signature:** _____ **Date:** _____

**Signing here means that you have read this form and all accompanying literature related to this event and agree to all statements given.

Date Rec'd: _____

Amount Rec'd: _____