Medical Release Form
Teach Homeschool Support Organization

Parent's Names: _____
Home Address: _____
City, State: _____ Zip Code: _____
Phone(s): _____
Name of Family Doctor: _____ Phone: _____
Health Insurance Company: _____
Member Policy Number: _____
Secondary Contact Name: _____ Phone: _____

Child's Name: _____ Date of Birth: _____
List All Known Allergies: _____
Date of last Tetanus: _____

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Child's Name: _____ Date of Birth: _____
List All Known Allergies: _____
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General Emergency Medical Treatment
(Authorization to consent to Emergency Medical Treatment)

(I.) (I) (We), the (Parent(s)), (Guardians) of the child(ren) listed on this form, do hereby authorize the sponsor representing Teach Homeschool Support Organization (Teach), Bloomington, MN, whose classes meet in St. Louis Park, Assembly of God, in order that (my) (our) child(ren) may receive the proper medical treatment in the event that he/she may sustain injury or illness during the period of registered events. (I) (We) hereby authorize the staff to obtain or provide medical treatment for (my) (our) child (ren) for such injury or illness during the event, and (I) (We) hereby hold that event staff and Teach, as well as its representatives, harmless in the exercise of this authority. (II.) It is understood this authorization is given in advance of any specific diagnosis, treatment or hospital care requited but is given to provide authority and power on the part of aforesaid agent to give specific consent to any and all diagnosis, treatment & hospital judgment deemed advisable. (III.) This is to be effective for the scheduled events unless revoked in writing by to said sponsor. (IV) It is understood that, as parent(s) or guardian(s), (I) (We) are responsible for all medical costs and (I) (We) will not hold Teach of Bloomington, MN, any officer, board member, volunteer, drivers, or tutors, liable for medical aid rendered to (my), (our) child (ren).

Parent's (Legal Guardian) Name(s):

(Please print) _____ _____

Parent's (Legal Guardian) Signature(s):

_____ _____

Date :

_____