



Medical Release

In the event that I cannot be contacted and my child, _____ should need medical attention, I give North Cross permission to provide necessary medical attention. I further consent to medical, surgical, and/or hospital care treatment and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health.

I also give permission for my child to be transported by ambulance or staff car to the nearest medical emergency center or clinic for medical treatment should the Director feel the situation is life-threatening.

The following are the Physician and Hospital I wish my child's medical attention be given by:

Child's Physician _____

Physician's Address _____

Physician's Phone # _____ Preferred Hospital _____

Insurance Company _____ Insurance Phone # _____

Insurance Policy # _____ Group # _____

Child's Medical Information

Known Allergies or Illnesses: _____

In the event of an allergic reaction or if my child should be exposed to the above, please take the following action:

Please list any medications your child is currently taking and why: _____

Please Note: When signing this form you are indicating that your child is free of any contagious diseases and in good physical condition able to participate in regular activities.

Parent Name (please print) _____

Parent Signature _____ Date _____