

GCMS MIDDLE SCHOOL MEDICAL RELEASE FORM

I, WE _____ OF _____
NAME CITY

_____ COUNTY, IL SO HEREBY STATE THAT I or WE ARE THE NATURAL
PARENT(S) OR LEGAL GUARDIAN(S) HAVING LEGAL CUSTODY IF _____
CHILD'S NAME

A MINOR AGE ____ BORN _____, WHO RESIDES WITH ME/US AT

ADDRESS

I AUTHORIZE ANY COACH OF THE GCMS SCHOOL DISTRICT, COUNTY OF FORD, STATE OF ILLINOIS TO CONSENT TO ANY X-RAY, EXAMINATION, ANESTHETIC, MEDICAL OR SURGICAL DIAGNOSIS OR TREATMENT, AND HOSPITAL CARE, TO BE RENDERED TO THE MINOR UNDER GENERAL OR SPECIAL SUPERVISION, AND ON THE ADVICE OF ANY PHYSICIAN OR SURGEON LICENSED TO PRACTICE IN THE STATE OF ILLINOIS, WHEN THE NEED FOR SUCH TREATMENT IS IMMEDIATE, AND WHEN EFFORTS TO CONTACT ME (US) ARE UNSUCCESSFUL.

SIGNATURE PARENT OR GUARDIAN

DATE

CHILD'S DOCTOR _____

CHILD'S ALLERGIES _____

PARENT/GUARDIAN EMERGENCY CONTACT NUMBER _____

MEDICINES CHILD IS TAKING _____

OTHER MEDICAL CONSIDERATIONS, OR SPECIAL INSTRUCTIONS (OPTIONAL)

