Medical Release Form
Corner-Stone Church Preschool

AUTHORIZATION TO CONSENT TO MEDICAL TREATMENT OF CHILD

I, (legal parent or guardian's full name) _____, make oath and say that I am the lawful guardian of the child listed below and there are no court orders now in effect that would prohibit me from conferring the power to consent upon another person.

Child

(Child's full legal name) _____, (child's gender) ___Female_____, born on (child's birthdate) _____and residing at (child's residential address) _____

_____

Currently on the following medications:

(List all over-the-counter medications/supplements, as well as prescription drugs/treatments of child)

_____

_____

_____

Important allergies, illness, and/or medical information:

_____

_____

_____

I hereby authorize and appoint the staff at Corner-Stone Church Preschool as my agents. My agents may consent to my child's medical examination or treatment. Such treatment may include but is not limited to the following:

- Transportation by ambulance
- Examination
- X-rays
- Diagnoses
- Hospitalization
- Anesthesia
- Medication

My child's primary care physician is (Child's primary physician name) _____, located in (location of physician's office) _____

with the phone number of _____.

I give this consent freely and knowingly in order to provide for my child, and not as a result of pressure, threats, or payments by any person or agency.

This consent will remain in effect until it is revoked by notifying my child's medical, mental health care, and insurance providers, in writing, and the agent named above that I wish to revoke it.

Any questions or concerns regarding this authorization may be directed to me at:

Address _____

City _____ State _____ Zip _____

Cell Phone _____ Home Phone _____

Work Phone _____ Email_____

IN WITNESS WHEREOF, I hereby sign my name,

(Witness's signature) _____

(Witness's name in print) _____

on this date of _____.

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