

**MEDICAL RELEASE FORM**

To: Emergency Personnel

I hereby give my consent to any emergency medical personnel to administer necessary treatment to my child, \_\_\_\_\_, in the event of an emergency at which time I cannot be reached. I give consent to transport by ambulance if the situation warrants it.

I hereby grant permission for my son/daughter to participate in any and all sports and all extra-curricular activities. I waive, release, absolve, and hold blameless Free Life Chapel and Excel Christian Academy and their administrators, teachers, supervisors, physical education directors, managers, persons transporting my child to and from school activities and other participants, from any claim arising out of an injury or sickness to my child. I authorize the personnel at Excel Christian Academy to administer first aid to my child in the event of their involvement in an accident, injury or sickness.

**THIS FORM MUST BE NOTARIZED**

\_\_\_\_\_  
SIGNATURE OF PARENT OR LEGAL GUARDIAN

State of Florida

County of Polk

\_\_\_\_\_  
DRIVERS LICENSE #

On the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_, before me came \_\_\_\_\_, to me known to be the individual described in and who executed the same.

\_\_\_\_\_  
NOTARY PUBLIC

My Commission Expires: \_\_\_\_\_

**EMERGENCY INFORMATION:**

Child's Doctor \_\_\_\_\_ Office Phone \_\_\_\_\_

Hospital Preference \_\_\_\_\_

**PICK-UP/ EMERGENCY LIST:** Please list the people who are allowed to pick up your child from Excel Christian Preschool AND can be contacted in case of an emergency. It is the sole responsibility of the parent to notify the school of any changes to this list.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_ Other # \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_ Other # \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_ Other # \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_ Other # \_\_\_\_\_

**Medical History:**

Previous hospitalization? ( ) No ( ) Yes- If yes, why? \_\_\_\_\_

Is child allergic to anything? ( ) No ( ) Yes If yes, what? \_\_\_\_\_

Is the child under the care of a doctor? ( ) No ( ) Yes If yes, for what reason? \_\_\_\_\_

Does child take any prescribed medications on a daily basis? ( ) No ( ) Yes- If yes, please list \_\_\_\_\_

**NOTICE:** No medication will be dispensed without a written prescription (i.e. Tylenol, Motrin, etc)

Any history of convulsions? Asthma ( ) No ( ) Yes- If yes, please list \_\_\_\_\_

Are there any special instructions that we should know about? ( ) No ( ) Yes- If yes, please list: \_\_\_\_\_

Explain: \_\_\_\_\_