

SMOKY VALLEY HOME EDUCATORS CO-OP MEDICAL RELEASE


Family Last Name _____
Father's Name _____ Mother's Name _____
Father's Phone Number _____ Mother's Phone Number _____
Home _____ Work _____
Work _____ Cell _____
Cell _____

Children's Names	Birthdate/Age	Allergies/Medical Problems?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Emergency Contact _____
Relationship to Children _____
Phone Numbers: Home _____ Work _____
Cell _____

Name of Family Doctor _____ Phone Number _____
Name of Health Insurance _____
Policy Number _____
Name of Insured _____

I, _____ (parent/guardian) of above children (minors) understand above children will be supervised during co-op classes, choir, and band and that if serious injury or illness develops, medical and/or hospital care will be given. I hereby give my permission to the attending physician to perform the following, but not limited to, activities: hospitalization, diagnosis including taking specimens and x-rays, giving blood transfusions, injections, and medications, anesthesia, and surgery for my child. I affirm that the information set forth above is true and correct to the best of my knowledge. I also understand that the leaders of Smoky Valley Home Educators Co-op will attempt to contact me prior to securing medical treatment, but that this consent is given in case I am not available in an emergency.

Parent Signature  _____ Date _____