Faith Church Student Ministries Parent Consent Medical Release Form
1895 State Road 44, Martinsville, IN 46151

Student's Name: ____________________________ D.O.B. _______________

Address: ____
City: _______________________, State: ______ Zip: ____________
Phone: 1) _____________________________________
2) _____________________________________

Insurance Company: _____________________________ Policy #:_________________

Allergies:

Medication:

Extra Information:

Signature of Parent/Guardian: ____
Date: _______________________
Secondary Contact: ______________________________ Phone: __________________

In the case of medical emergency, I understand that hospital policy requires parental permission before treatment. I hereby give my permission to a representative of Faith Church, Martinsville, Indiana to administer medication as identified above and to secure proper medical treatment. Parents will be notified immediately of any medical emergency.