



FAITH, FAMILY, FRIENDS

Broken Arrow Church of Christ

MEDICAL RELEASE FORM

I (we) the undersigned parent (s) of _____,
a minor, do hereby authorize and empower adult sponsors with the Broken Arrow
Church of Christ to consent to any examination, x-ray, anesthetic, medical or
surgical diagnosis or treatment and/or hospital care which is deemed necessary to
protect the life and health of said child. Any care rendered will be under supervision
of a licensed physician, surgeon, or nurse.

Date _____

Parent or Guardian _____

Witness _____

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Full Name _____ Birth Date _____

Street Address _____ City & State _____

Emergency Contact:

Parent/Guardian Name _____ Cell Phone _____

Place of Employment _____

Parent/Guardian Name _____ Cell Phone _____

Place of Employment _____

Health Insurance Co _____ Policy Number _____

Family Physician _____

Allergies or Special Conditions: