MEDICAL RELEASE FORM

To Whom It May Concern:

I, the parent and/or legal guardian of ____
grant permission for medical treatment of the above person in the event of an emergency illness and/or accident and I release Atlantic Northeast District and all volunteer personnel from all liability or medical expense incurred. An effort will be made to contact me prior to any treatment. Where contact cannot be made, proper medical personnel have my permission to proceed as determined by medical opinion.

Please list any known allergy to medications ____
____

Atlantic Northeast District
Junior High Retreat
October 23-25, 2015

Signed ___________________________________
Phone ____________________________________
Congregation ______________________________

PLEASE BRING THIS FORM TO THE EVENT

MEDICAL RELEASE FORM

To Whom It May Concern:

I, the parent and/or legal guardian of ____
grant permission for medical treatment of the above person in the event of an emergency illness and/or accident and I release Atlantic Northeast District and all volunteer personnel from all liability or medical expense incurred. An effort will be made to contact me prior to any treatment. Where contact cannot be made, proper medical personnel have my permission to proceed as determined by medical opinion.

Please list any known allergy to medications ____
____

Atlantic Northeast District
Junior High Retreat
October 23-25, 2015

Signed __________________________________
Phone ___________________________________
Congregation _____________________________