**RELEASE FORM**

**1.**Pursuant to the provision of the civil code of the State of Kentucky, I the undersigned, legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a minor, do hereby authorize, as agents, the adult supervisors of the student ministry department of Center Point Church, Lexington, Kentucky, to consent to any diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical Practice or by a dentist licensed under the provisions of the Dental Practice Act. It is understood that this authorization is given in advance of any specific care being required, but it given to provide authority to give care which physician may, in the exercise of his/her best judgment, deem advisable. **2**. I hereby authorize that the Center Point Church leaders that have training as Emergency Medical Technicians or Registered or Licensed Nurses may perform care upon my child in accordance with the level of training they have received as deemed necessary by them. **3**. I hereby authorize any hospital which has provided treatment to the above named minor to surrender physical custody of such minor to my above named agent upon completion of This authorization is given pursuant to the Health and Safety Code. **4.** I hereby release Center Point Church of Lexington, Kentucky and its’ leaders (both paid and volunteer staff) from liability in case of accident. **5**. I hereby request the above named agent to carry out discipline deemed necessary for my child. I also agree to pay the expenses of my child’s trip home because of disciplinary action. **6**. These authorizations shall remain effective until revoked in writing and delivered to said agent.

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Circle one: PARENT / LEGAL GUARDIAN / PERSON HAVING LEGAL CUSTODY (explain on back)

**Student Information:**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Soc Sec Num \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

County \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Information:**

(Please check and specify any past history or condition on back of form) \_\_\_\_\_\_ Allergies \_\_\_\_\_ Asthma \_\_\_\_\_ Diabetes \_\_\_\_\_ Heart Condition \_\_\_\_\_ Hypoglycemia \_\_\_\_\_ Epilepsy or other nervous disorders \_\_\_\_\_ Other \_\_\_\_\_\_\_\_\_\_ Last year of Tetanus Shot Home Phone (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pager/Mobile Phone (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Insurance Carrier \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Family (student’s) Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 7/08

**PARENT/GUARDIAN INFORMATION**:

Father’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Contact # (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Primary Contact # (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­\_