GCMS MIDDLE SCHOOL MEDICAL RELEASE FORM

I, WE _____ OF _____
NAME CITY

_____ COUNTY, IL SO HEARBY STATE THAT I or WE ARE THE NATURAL
COUNTY

PARENT (S) OR LEGAL GUARDIAN (S) HAVING LEGAL CUSTODY OF _____
CHILDS NAME

A MINOR AGE _____ BORN _____, WHO RESIDES WITH ME/ US AT _____.
DATE ADDRESS

I AUTHORIZE ANY COACH OF THE GCMS SCHOOL DISTRICT, COUNTY OF FORD, STATE OF ILLINOIS TO CONSENT TO ANY X-RAY, EXAMINATION, ANESTHETIC, MEDICAL OR SURGICAL DIAGNOSIS OR TREATMENT, AND HOSPITAL CARE, TO BE RENDERED TO THE MINOR UNDER GENERAL OR SPECIAL SUPERVISION, AND ON THE ADVICE OF ANY PHYSICIAN OR SURGEON LICENSED TO PRACTICE IN THE STATE OF ILLINOIS, WHEN THE NEED FOR SUCH TREATMENT IS IMMEDIATE, AND WHEN EFFORTS TO CONTACT ME (US) ARE UNSUCCESSFUL.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN DATE

CHILDS DOCTOR _____

CHILDS ALLERGIES _____

PARENTS DOCTOR _____

MEDICINES CHILD IS TAKING _____

OTHER MEDICAL CONSIDERATIONS, OR SPECIAL INSTRUCTIONS (OPTIONAL)

_____

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