



Cathedral of the Incarnation
 1515 Edgewater Drive • Orlando, FL 32804 • (407) 843-2886

MEDICAL RELEASE FORM

I, _____ (Parent/Guardian's Name) hereby give permission for any and all medical attention to be administered to my child _____ (Child's Name) in the event of accident, injury, sickness, etc., under the direction of the person(s) listed below, until such time as I may be contacted. I also assume responsibility for the payment of any such treatment. This release is effective for the period of one year from the date given below.

ADDRESS: _____

* _____

HOME PHONE: _____

INSURANCE COMP: _____

POLICY NUMBER: _____

In case I cannot be reached, any of the following persons is designated to act on my behalf.

*Church Official: **Mark Siegel**

*Church Official: **John Larsen**

*Church Official: **Kim Campese**

*Church Representative: _____

PHYSICIAN: _____

ADDRESS: _____

PHONE: _____

KNOWN ALLERGIES / MEDICATIONS: _____

SIGNATURE (PARENT/GUARDIAN) _____ DATE _____

Witnessed this _____ day of _____, 20_____ .

WITNESS (SIGNATURE)

(PRINT NAME)

