



# Medical Release Form

I, \_\_\_\_\_, a legal resident of the State of Texas, do hereby make, constitute, and appoint, **Jonathan Wright, John Casey, Tammy Casey, Peggy Crawford, Jody Payne, Lorrie Payne, Wayne Philpot, Paul Reynolds, Becki Reynolds, Mark Romine, Jan Romine, Brenda Simmons** as my son/daughter's true guardians:

To consent to any x-ray examination, anesthetic, medical/surgical treatment or diagnosis, and hospital care to be rendered to my daughter/son \_\_\_\_\_ under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the United States of America, and to consent to any x-ray examination, anesthetic, dental, or surgical treatment or diagnosis and hospital care to be rendered to my child under the general or special supervision and on the advice of any dentist or physician licensed to practice in the United States of America.

I grant to my said guardians in fact full power and authority to do and perform all and every act and things whatsoever requisite, necessary, and proper to be done in the exercise of any of the rights and powers herein granted, as fully to all intents and purposes as I might or could do if personally present, with full power of substitution or revocation, hereby ratifying and confirming all that my said guardians in fact or other substitutes shall lawfully do or cause to be done by virtue of this special release and the rights and powers herein granted.

The rights, powers, and authority of said guardians to exercise any and all of the rights and powers herein granted shall commence and be in full force and effect on the date listed below, and such rights, powers, and authority shall remain in full force and effect thereafter until revoked by me in writing.

DATED this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_.

\_\_\_\_\_  
Signature



# Information Sheet

**To be filled out by parent or guardian:**

Name of student \_\_\_\_\_ Social Security # \_\_\_\_\_  
Home Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

In an emergency notify \_\_\_\_\_ Phone \_\_\_\_\_  
Name of parent or guardian \_\_\_\_\_ Phone \_\_\_\_\_  
Address of parent or guardian \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Business Phone \_\_\_\_\_ Evening Phone \_\_\_\_\_

**Insurance Information:**

Insurance Carrier \_\_\_\_\_ Policy # \_\_\_\_\_  
Name on Policy \_\_\_\_\_ and Social Security # \_\_\_\_\_  
Name of Family Physician \_\_\_\_\_ and Phone \_\_\_\_\_

**Medical History:**

Known diseases or conditions: Asthma, heart, kidney, epilepsy, diabetes, anemia, lungs, allergies \_\_\_\_\_ TB Update \_\_\_\_\_  
Difficulties: Nose bleeds, sore throats, colds, bed-wetting  
Other \_\_\_\_\_  
Physical handicaps or deformities \_\_\_\_\_  
Is student taking medication? \_\_\_\_\_ Type \_\_\_\_\_  
How often \_\_\_\_\_ Dosage \_\_\_\_\_

**Parent or Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Additional Information or Comments:**

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