TRINITY WORLD OUTREACH CENTER

MEDICAL RELEASE

Name of Child Participant ____

I understand that in the event medical treatment is required, every effort will be made to contact me   However, if I cannot be reached, I give my permission to Trinity World Outreach Center or an adult sponsor to secure the services of a licensed physician to provide the care necessary, including anesthesia, for my child's well-being.

Physician's Name _____________________________________Phone _____________

Please list any medical allergies, medications being taken, medical problems, or other pertinent information
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Name of Insurance Co. ________________________________Policy No. __________

Signed ____ Date ______________
(Parent or Legal Guardian)