



## **Medical Release Form**

### **Student Information**

Name \_\_\_\_\_ Address \_\_\_\_\_  
City / State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
Age \_\_\_\_\_ Male / Female (circle one)

### **Parent / Legal Guardian Information**

Relationship to student:    Parent            Legal Guardian            Legal Custody  
Name \_\_\_\_\_ Address \_\_\_\_\_  
City / State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_  
Medical Insurance Carrier \_\_\_\_\_  
ID # \_\_\_\_\_  
Pediatrician: \_\_\_\_\_ Phone \_\_\_\_\_

1. I, the undersigned, legal guardian of \_\_\_\_\_, a minor, do hereby authorize, as agent(s), the adult supervisor of Victory Christian Academy, 618 West Ripa Avenue, St. Louis, MO, 63125, to consent to any diagnosis or treatment, and hospital care, which may be required, if the above named guardian cannot be reached.
2. It is understood that this authorization is given in advance of any specific care being required, but it is given to provide the agent the authority to approve care, which a physician may, in the exercise of his / her best judgment, deem advisable and necessary.
3. I hereby authorize any hospital, which has provided treatment to the above named minor to surrender physical custody of such a minor to the agent currently supervising the minor upon completion of treatment.
4. I hereby release Victory Christian Academy and the agent from liability in approval of care as recommended by a physician.
5. These authorizations shall remain effective until revoked in writing, delivered to said agent.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Student Medical Information**

List any medications, allergies, special conditions or health problems, etc.:

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