

Collin County Chinese Fellowship Church Medical Release Form

Father/Mother/Guardian's Name: _____

Home Address: _____
Street
City
Zip

Home Phone: _____ Cell Phone: _____

Name of Child: _____ Date of Birth: _____ Age: _____	Name of Child: _____ Date of Birth: _____ Age: _____
<i>Are there any restrictions on normal physical activities?</i> Yes__ No__ If yes, please specify _____ _____	<i>Are there any restrictions on normal physical activities?</i> Yes__ No__ If yes, please specify _____ _____
<i>Does your child have a chronic medical condition necessitating dietary supplement or restrictions?</i> Yes__ No__ If yes, please specify _____ _____	<i>Does your child have a chronic medical condition necessitating dietary supplement or restrictions?</i> Yes__ No__ If yes, please specify _____ _____
<i>Is your child allergic to any of the following? (Circle as appropriate)</i> <input type="checkbox"/> Insect bites <input type="checkbox"/> Sun <input type="checkbox"/> Pollen <input type="checkbox"/> Motion sickness <input type="checkbox"/> Prone to over exertion <input type="checkbox"/> Foods (please specify) _____ Other _____	<i>Is your child allergic to any of the following? (Circle as appropriate)</i> <input type="checkbox"/> Insect bites <input type="checkbox"/> Sun <input type="checkbox"/> Pollen <input type="checkbox"/> Motion sickness <input type="checkbox"/> Prone to over exertion <input type="checkbox"/> Foods (please specify) _____ Other _____
<i>Is your child allergic to any medications?</i> Yes__ No__ If yes, please specify _____ _____	<i>Is your child allergic to any medications?</i> Yes__ No__ If yes, please specify _____ _____
<i>Date of last tetanus(破傷風) shot?</i> Date: _____	<i>Date of last tetanus(破傷風) shot?</i> Date: _____

Emergency Medical Care:

 Doctor Address Phone

 Hospital Address Phone

I hereby authorize to take my child to the above-named physician or facility for medical treatment in the event of an emergency in which neither parent/guardian can respond. I also authorize any licensed physician or medical treatment center to treat my child in case of an emergency in which the above-named physician cannot respond.

 Name Signature Date