

MEDICAL RELEASE FORM
THE TRAINING CENTER

PLEASE PRINT CLEARLY

STUDENT INFORMATION

Last Name _____
Email _____
First Name _____ Date of Birth _____
Mother's Name _____ Father's Name _____
Address _____ City _____ TX , Zip _____
Sex _____ Height _____ Weight _____ Last Tetanus Shot _____

PHONE NUMBERS

Home Number _____ Mom Cell _____
Work # _____ Dad Cell _____

MEDICAL INFORMATION

Please describe any medical condition your child has _____

Does your child have food allergies? NO YES EXPLAIN _____

Does your child have any allergies? NO YES EXPLAIN _____

Has your child ever had any seizures? NO YES EXPLAIN _____

Has your child ever had any signs of asthma? NO YES EXPLAIN _____

Please list any medical treatments you DO NOT authorize your child to receive. _____

EMERGENCY NUMBERS

Family Physician _____ Phone _____
Name _____ Relationship _____ Phone _____
Name _____ Relationship _____ Phone _____

INSURANCE INFORMATION

Name of insured _____ Employer _____
Address _____ City _____ TX Zip _____
Certification Phone _____ Policy # _____ Group# _____

Medical Information and Release Form

MEDICAL RELEASE

I hereby acknowledge and agree to the following:

I hereby give my approval for my child _____, to participate in the classes at The Training Center

I agree to assume all risks and hazards which may occur during my child's participation in this program. I hereby waive, release, and agree to hold harmless The Training Center, Sam Lund, Jan Lund, Bobby Cantrell, Linda Cantrell and Tim Cantrell,

and any volunteers from any injuries, harm or other damages that may occur to me or my child in connection with The Training Center.

In the event that I cannot be reached to make arrangements for emergency medical treatment I authorize Jan Lund or Linda Cantrell to obtain and

authorize any medical services and treatment that the medical staff deems necessary. This may include, but is not limited to, transportation

to the nearest facility for treatment. Jan Lund or Linda Cantrell has my permission to sign any forms and to ensure emergency treatment.

Parent _____ Date _____