MEDICAL RELEASE

Child's Name: _____
(Printed)

We/I hereby give authorization and consent for the rendering to our/my child, _____, by a licensed physician or physicians, such medical services and treatment as may become necessary or advisable during the time my child is in the care of Holy Trinity Greek Orthodox Preschool, regardless of whether such treatment or services become necessary by reason of an emergency, unanticipated conditions, or otherwise. Such consent and authorization shall include the cooperation and assistance of any qualified medical personnel working under the supervision of licensed physicians.

We/I hereby acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment of our/my child's condition.

We/I hereby acknowledge that we are (I am) responsible for all charges in connection with care and treatment rendered.

We/I hereby give authorization for the use of 911 medical services for immediate treatment and transportation in emergency situations.

In case of emergency, we/I would like for our/my child to be cared for at: _____ Hospital in Charlotte, North Carolina.

Parent / Mother Signature: _____ **Date:** _____

Parent / Mother Name: _____
(Printed)

Parent / Father Signature: _____ **Date:** _____

Parent / Father Name: _____
(Printed)

******This form must be signed by both parents/guardians.******
In the case of divorce, the parent with custody of the minor child must sign.