

TEC Medical Release Form

Name of TEC Participant _____

I (we) authorize an adult, in whose care the minor has been entrusted, to consent to any X-ray examination, anesthetic, medical, surgical or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed under the provisions of the applicable law and an active member of the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of any such physician or any such hospital.

The undersigned shall be liable and agrees to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

PLEASE COMPLETE THE FOLLOWING INFORMATION:

Do you have medical insurance? Yes No (please check one)

Insurance Company: _____

Policy Number: _____

Name of Policy Holder: _____

Company customer service number: _____

If we need to take your child to the hospital during the TEC weekend, please list the hospital you prefer:

Name _____

Address _____

Phone _____

How can we contact you during the weekend?

Home phone: _____

Cell phone: _____

Alternate contact:

 Name: _____

 Phone: _____

Other: _____

Please list any allergies, medical problems, current medications, etc. you think would be important for us to know about:

Parent(s) name (please print) : _____

Parent(s) signature: _____

Date: _____