TRINITY BAPTIST WEEKDAY PRESCHOOL
4815 Six Forks Road
Raleigh, NC 27609
(919) 782-6192

MEDICAL RELEASE/PERMISSION FORM

Child's Name_____

Address_____

_____ Zip Code_____

Date of Birth_____Place of Birth_____

Child's Physician_____Phone_____

Address_____

Child's Dentist_____Phone_____

Address_____

AUTHORIZED ADULTS

Mother's Name_____Phone_____

Father's Name_____Phone_____

Alternate Person to Contact_____

Relation_____Phone_____

Describe any physical problems, allergies, conditions, or medications your child may have:_____

_____

Name of Insurance Company_____

Policy Number_____(or) Group Name_____

Group Number_____Phone_____

Any additional information or instructions may be list on the reverse side.

-over-

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Permission is hereby given for the staff of Trinity Baptist Weekday Preschool to obtain emergency or medical treatment for my child at Duke Raleigh Hospital, 3400 Wake Forest Road, Raleigh NC. I authorize the transfer of my child's health record to Duke Raleigh Hospital as needed for treatment.

Parent's or Guardian's Signature and Date:

_____Date_____

NORTH CAROLINA
WAKE COUNTY

I, _____, a Notary Public for said County and State do

hereby certify that _____appeared before

me this day and acknowledged the due execution of the foregoing statement.

Witness my hand and official seal, this the _____day of

_____, 20_____.

_____
Notary Public

My Commission Expires_____of 20____.