

 **MO SAIC ACADEMY**
MEDICAL RELEASE FORM

Child's Name: _____

Birthdate: _____

Address: _____

Phone: _____ Cell: _____

Please list anyone who is authorized to pick your child up from school:

Name: _____ Driver's License: _____

Phone: _____

Name: _____ Driver's License: _____

Phone: _____

Name: _____ Driver's License: _____

Phone: _____

In case of emergency, I give Mosaic Academy staff permission to seek medical attention for my child, _____.

In the event that medical care is necessary, I prefer that treatment be sought at _____ . I understand that every effort will be made to contact me before any action is taken.

Parent's signature: _____ Date: _____

Parent's signature: _____ Date: _____