

**LifeShine - Medical Information and Release Form**

**One form per enrolled child**

Child's Name: \_\_\_\_\_

Emergency Contact Name(s): \_\_\_\_\_

Emergency Contact Phone #: \_\_\_\_\_

Child's Physician: \_\_\_\_\_

Physician's Phone: \_\_\_\_\_

Allergies to medication: \_\_\_\_\_

Medicines taken regularly: \_\_\_\_\_

Other information needed in event emergency treatment is required:

\_\_\_\_\_  
\_\_\_\_\_

**Insurance Information**

Primary Insured: \_\_\_\_\_

Relationship: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Member Group # \_\_\_\_\_

Insurance Company Phone Number: \_\_\_\_\_

In the event that I am unavailable and cannot be contacted during an emergency medical situation, I give permission to any LifeShine administrator or teacher to call an ambulance and/or transport my child(ren) to the nearest medical facility for emergency care. I will assume full financial responsibility for all expenses incurred.

\_\_\_\_\_  
Print Parent's Name

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date