

## 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.

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**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:

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Parent(s) name (please print) : \_\_\_\_\_

**Parent(s) signature:** \_\_\_\_\_

Date: \_\_\_\_\_