MEDICAL RELEASE FORM

ACE Academy Administrator:

In the event that _____needs medical care during his/her official participation in the **ACE Academy,** you have my permission to arrange for medical treatment when necessary and performed by a licensed qualified physician. (Parent/guardian to be notified in case of emergency.)

Student Name_____

Address_____

Date of Birth: (Month)_____(Day)_____(Year)_

Home Phone No._____Parent/Guardian Work No._____

Medical/Health Insurance Company_____

I.D. #, Group/Contract#, Benefit#_____

Does student have allergies to medication or other important medical factors?
_____Yes _____NO

If yes, please explain_____
_____
_____

Prescribed medication/condition or physical handicap_____
_____
_____

Person other than parent/guardian to be contacted in case of emergency:

Name_____Phone_____

_____ _____
Parent/Guardian Signature **Date**