



Medical Information/Photo Release for Volunteers and Minor Children

Date: _____

Parents/Guardian/Volunteer Name: _____

Minor Child's Name: _____ DOB: _____

Allergies: _____ Medical/Special Problems: _____

Medical Insurance Information

Name of Insurance Company: _____

Policy/Group ID Number: _____

Name, Phone Number

Family Physician(s): _____

Siblings over 18: _____

Grandparents: _____

I/We, being the parent(s) or legal guardian(s) of the above named minor children hereby appoint MTG to act in my/our behalf in authorizing unexpected medical care, dental care, and hospitalization for the above named minor(s) during the period of my/our absences from:

_____ through _____
Month/day/year Month/day/year

This document shall be presented to a physician, dentist, or appropriate hospital representative at such times as unexpected medical care, dental care, and/or hospitalization may be required.

Parent/Guardian/Volunteer

Signature

We, the parents, can be reached in an emergency:

Place: _____ Phone: _____

Place: _____ Phone: _____

MTG sometimes uses photos from classes/events for use in publicity materials. Children's names will be withheld from these materials unless parent consent is obtained. I authorize the use of my/my child's photo for publicity purposes.

- Yes, I consent use of my photo/my child's photo for MTG publicity purposes.
- No, I do not wish for my photo/my child's photo to be used for MTG publicity.