Boonville church of Christ

406 N 2nd St | PO Box 28  
Booneville, MS 38829  
Phone: 662-728-5544

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Consent, Discipline, & Medical Release Form

I, the undersigned parent (guardian) of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, a minor, do hereby authorize adult workers of the Booneville church of Christ to consent any examination, x-ray, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is rendered under supervision of doctors or any physician or surgeon licensed under provisions of the Medical Practice Act on the medical staff or licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital.

Further, as a parent (guardian) of the minor named above, I do hereby expressly consent that my son/daughter may receive emergency medical treatment from doctors or any physician, hospital, or other medical center without necessity of notifying me, and do further agree to hold harmless any physician, hospital, or other medical center for rendering such services.

I/we also agree that Booneville church of Christ and its staff members will not be held responsible in case of accident. I/we will never bring legal action against Booneville church of Christ or its staff.

As a Parent (guardian) of the above child, I understand that in extreme discipline situations, I am responsible to pay my child’s transportation home.

Parent/Guardian Signiture\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_city/state/zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Policy #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Medications\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Include specific heath concerns )