ORTHODOX DETROIT OUTREACH (ODO) -- SS. PETER AND PAUL(SSPP)
MEDICAL RELEASE FORM

Participant's Legal Name: _____ *Date of Birth:* ____/____/____

Social Security Number: ____-____-____ *Place of Birth:* _____
City, State, Country

Current Address: _____ *Home Phone:* (_____) _____-_____

_____ *Cell Phone:* (_____) _____-_____

Parent/Legal Guardian, If Participant under 18: _____

Family Physician: _____ *Phone:* (_____) _____-_____

Insurance Company: _____

ID Number: _____ *Policy Number:* _____ *Group Number:* _____

Date of Last Tetanus: ____/____/____ *Allergies:* _____

Blood Type: _____

Special Medication, medical disorders and instructions: _____

I, _____hereby authorize the participation of my child, _____, in all official activities during the ODO/SsPP Work Event scheduled for _____.

IN THE EVENT OF ILLNESS, INJURY, OR EMERGENCY, I give my permission for the Group Leader, _____, to make decisions regarding medical treatment. I also authorize the physician selected by the Group Leader to secure proper treatment, to hospitalize and/or to order injection, anesthesia or surgery for the participant named above.

The Parent/Legal Guardian does hereby authorize the Group Leader of the Organization to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon licensed under the laws of the State or Country in which the medical care is being sought and on the medical staff of any hospital; or to consent to any X-ray examination, anesthetic, dental or surgical diagnosis or treatment to be rendered to the Minor by any dentist licensed under the laws of the State or Country in which the dental care is being sought.

It is understood that this authorization is given in advance of any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care being required but is given to provide authority and power on the part of the Group Leader to give specific consent to any and all such examination, anesthetic, diagnosis, treatment, or hospital care which the aforementioned surgeon, physician and/or dentist, in the exercise of his/her best judgment, may deem advisable.

The Parent/Legal Guardian/Legal Guardian hereby authorizes any hospital which has provided treatment to the Minor to surrender physical custody of the Minor to the Group Leader upon the completion of treatment.

The Parent/Legal Guardian hereby agrees to fully pay all costs of medical or dental care incurred for the Minor by the Designated Agent under his authorization.

These authorizations shall remain effective until _____ unless sooner revoked in writing delivered to said Group Leader.

The Parent/Legal Guardian does hereby authorize the Group Leader of the Organization to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of, any physician and surgeon licensed under the laws of the State or Country in which the medical care is being sought and on the medical staff of any hospital; or to consent to any X-ray examination, anesthetic, dental or surgical diagnosis or treatment to be rendered to the Minor by any dentist licensed under the laws of the State or Country in which the dental care is being sought.

It is understood that this authorization is given in advance of any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care being required but is given to provide authority and power on the part of the Group Leader to give specific consent to any and all such examination, anesthetic, diagnosis, treatment, or hospital care which the aforementioned surgeon, physician and/or dentist, in the exercise of his/her best judgment, may deem advisable.

The Parent hereby authorizes any hospital which has provided treatment to the Minor to surrender physical custody of the Minor to the Group Leader upon the completion of treatment.

The Parent hereby agrees to fully pay all costs of medical or dental care incurred for the Minor by the Group Leader under his/her authorization.

These authorizations shall remain effective until _____ unless sooner revoked in writing delivered to said Group Leader.

Signed: _____ Date: ____/____/____
(Participant)

Signed: _____ Date: ____/____/____
(Parent/Legal Guardian if Participant is under age of 18)