Medical Release Form

To be completed by parent or guardian of dependent student

Kentucky Mountain Bible College

Name of student: _____

Address: _____

Phone: ( ) _____

Person responsible for medical bills: (parent/guardian)

Name: _____

Address: _____

Phone: ( ) _____

Insurance Company: _____

Member Number: _____

Policy No. _____

Copy of Insurance Card: (Please Attach) _____

In the case of an accident, notify one of the following persons:

Name: _____

Address: _____

_____

City State Zip

( ) _____

Home Phone Number

( ) _____

Work Phone Number

Name: _____

Address: _____

_____

City State Zip

( ) _____

Home Phone Number

( ) _____

Work Phone Number

I hereby authorize the physician chosen by Kentucky Mountain Bible College, in case of injury to my son or daughter, to perform such examination, procedure, and treatments as may be necessary in my absence upon said dependent son or daughter to relieve such conditions that he or she may encounter.

I further consent to the administration of anesthesia to be applied by or under the direction of the physician chosen by Kentucky Mountain Bible College or his designated assistants to said dependent. I assume responsibility for expenses incurred.

I understand that in the State of Kentucky, the age of majority is eighteen years for both sexes and at that age the student can provide consent for his or her medical and surgical procedures.

_____ _____

Signature Date

_____

Relationship to Applicant