Providence Extension Program
Visitor Medical Release Form

Date of Visit: _____ Reason for Visit: _____
Name: _____
Date of Birth: _____ Grade Level: _____
Allergies/Medication: _____
Parent/Guardian Name (if under 18): _____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
Email: _____

In the event of an emergency, please list the name and contact information for the individual you would like us to contact:

Emergency Contact Information:
Name: _____
Relationship: _____
Home Address: _____
City: _____ State: _____ Zip Code: _____
Cell Phone: _____ Work Phone: _____

Medical Contact Information:
Doctor: _____ Contact #: _____
Dentist: _____ Contact #: _____

This information will be used in the event of an emergency.

I (We) give my (our) permission for the above named to be on the PEP Mason campus on _____ (date). PEP Mason meets at Grace Baptist Church, 5595 Mason Road, Mason, OH 45040.

I (We) release PEP Mason (staff/tutors/parents/volunteers) and Grace Baptist Church (staff/volunteers) from responsibility and liability for any injury that may be sustained during this visit. In the event of an emergency, I (we) authorize PEP Mason, as agent for me (us), to consent to any medical emergency treatment such as x-ray examination, medical, dental or surgical diagnosis, treatment and hospital care advised and supervised by a physician, surgeon, or dentist licensed to practice under the laws of the state where the services are rendered, either at a doctor's office or in a hospital. Parents will be notified as soon as possible.

_____ _____
Signature *Date*

_____ _____
Parent/Guardian Signature (if under 18) *Date*

Revised 8/30/2021