

**Congregation Albert Junior Youth Groups**  
**Annual Release and Emergency Medical Information and Authorization**

My child \_\_\_\_\_ has my permission to participate in all  
Congregation Albert Junior Youth Group sponsored events during the 2007-2008 school year.  
INITIAL: \_\_\_\_\_

I understand that my child will, at times, need to drive with a responsible adult chaperone. I give my  
child \_\_\_\_\_ permission to drive with a responsible adult. INITIAL: \_\_\_\_\_

Emergency Contact Information for Parents:

Home Phone: \_\_\_\_\_

Cell Phone:

Parent \_\_\_\_\_ Parent \_\_\_\_\_

Emergency Contacts Other Than Parents:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Number \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Number \_\_\_\_\_

Emergency Medical Care

Doctor \_\_\_\_\_ Address \_\_\_\_\_ Number \_\_\_\_\_

Hospital \_\_\_\_\_ Phone \_\_\_\_\_

Insurance: \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_

Does your child have any known food or drug allergies? \_\_\_\_ Yes \_\_\_\_ No If yes, please provide  
additional information \_\_\_\_\_

Is your child currently taking any prescription medication? \_\_\_\_ Yes \_\_\_\_ No If yes, please provide  
additional information \_\_\_\_\_

I hereby authorize Congregation Albert to take my child to the above-named physician or facility for  
medical treatment in the event of an emergency in which neither parent can be reached. I hereby authorize  
any licensed physician or medical treatment center to treat my child in case of an emergency in which the  
above-named physician cannot respond.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date