

Washington Street Church of Christ Medical Release Form

Washington St. Church of Christ  
P.O. Box 324  
Fayetteville, TN 37334

**PLEASE PRINT IN INK**

**Effective Dates:** 02/01/2019-02/01/2020

**Family Information**  
**(ONE PER FAMILY)**

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Medical Insurance Co: \_\_\_\_\_ Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: Home: \_\_\_\_\_ Work: \_\_\_\_\_

Physician: \_\_\_\_\_ Office Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Office Phone: \_\_\_\_\_