MEDICAL RELEASE FORM

I, _____ (Parent/Guardian's Name) hereby give permission for any and all medical attention to be administered to my child_____ (Child's Name)

In the event of accident, injury, sickness, etc., under the direction of the person(s) listed below, until such time as I may be contacted.

I also assume the responsibility for the payment of any such treatment.
This release is effective for the period of one year from the date given below.

ADDRESS:_____
_____
HOME PHONE: _____
INSURANCE CO.:_____
POLICY NUMBER:_____

In case I cannot be reached, any of the following persons is designated to action my behalf.
A JGMXT representative where my child is training.

PHYSICIAN: _____
ADDRESS: _____
PHONE: _____
KNOWN ALLERGIES:_____

SIGNATURE (PARENT/GUARDIAN)

_____DATE_____

Subscribed and sworn before me, this _____ day of _____ , 200__

_____
Notary Public