



Medical Release

Doctor's Name _____ Phone _____

Child's Name	Known Conditions	Allergies	Add'l Info.
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

In case of a medical emergency*, I hereby give my permission to the physician selected by the Space Probe Director(s) to secure proper treatment and/or hospitalization for child(ren), _____

Signature of parent or legal guardian _____ Date _____

****The Space Probe Director(s) will make every attempt to reach the parent/legal guardian listed, or the emergency contact given on your registration form.***



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