MEDICAL RELEASE FORM

Name: _____

Date of Birth: _____

Grade: _____ Age: _____

Home Phone: _____ Cell Phone: _____

Address:_____

_____

Name of Parent/Guardian:_____

Relationship: _____

Home Phone:_____

Work Phone: _____

Cell Phone: _____

Address: (if different from above) _____

_____

As a parent and/or legal guardian of _____,
I authorize the treatment by a qualified, licensed Medical Doctor of the above named minor in the event of a medical emergency, which in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Person(s) to notify if parent/guardian is unavailable:

Name: _____

Phone: _____ Relationship: _____

Name: _____

Phone: _____ Relationship: _____

Known allergies, including any allergies to medicine: _____

Any medical conditions, chronic illnesses, surgeries or other conditions which should be noted: _____

_____

Family Physician:_____

Phone: _____

Insurance Carrier: _____

Policy Number: _____

This release form is completed and signed with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Signature of Parent/Guardian: _____ Date: _____