

Medical Release Form

Parent/Legal Guardian Name: _____

Address: _____

Phone #s: Home (_____) _____ - _____

Work (_____) _____ - _____

Cell (_____) _____ - _____

Children's Names _____ List all Known Medical conditions, including food allergies and/or drug allergies. In addition, include any and all over-the counter and/or prescription drugs taken regularly

In an emergency, please contact: _____

Relationship to child/children: _____

Phone #s: (_____) _____ - _____

(_____) _____ - _____

Physician's Name: _____

Phone # (_____) _____ - _____

Primary Insurance Company: _____

Phone #: (_____) _____ - _____

Policy Holder's Name: _____

Relationship to child/children: _____

ID #: _____ Group Policy # _____

Secondary Insurance Company: _____

Phone #: (_____) _____ - _____

Policy Holder's Name: _____

Relationship to child/children: _____

ID #: _____ Group Policy # _____

Statement of Consent:

In the event of an emergency or non-emergency situation requiring medical treatment, I _____, hereby grant permission for any and all medical attention to be administered to my child/children, in the event of an accidental injury or illness, until such time as I can be contacted. This permission includes, but is not limited to, the administration of first aid, the use of an ambulance, and the administration of anesthesia and/or surgery, under the recommendation of qualified medical personnel.

Signature: _____ Dated: _____