

Medical Release Form

Parent/Legal Guardian's Name: _____

Address: _____

Phone #s: Home (____) _____ - _____

Work (____) _____ - _____

Cell (____) _____ - _____

Other (____) _____ - _____

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: (____) _____ - _____ (____) _____ - _____

(____) _____ - _____ (____) _____ - _____

Or contact: _____

Relationship to child/children: _____

Phone #s: (____) _____ - _____ (____) _____ - _____

(____) _____ - _____ (____) _____ - _____

Physician's Name: _____

Address: _____

Phone #s: (____) _____ - _____ (____) _____ - _____

Dentist's Name: _____

Address: _____

Phone #s: (____) _____ - _____ (____) _____ - _____

Primary Insurance Company: _____
Phone #s: (_____) _____ - _____ (_____) _____ - _____
Billing Address: _____
Policy Holder's Name: _____
Address: _____
Relationship to child/children: _____
ID #: _____ Group/Policy #: _____

Secondary Insurance Company: _____
Phone #s: (_____) _____ - _____ (_____) _____ - _____
Billing Address: _____
Policy Holder's Name: _____
Address: _____
Relationship to child/children: _____
ID #: _____ Group/Policy #: _____

Statement of Consent: *(To be signed in the presence of a legalized notary public.)*

In the event of an emergency or non-emergency situation requiring medical treatment, I, _____, hereby grant permission for any and all medical and/or dental 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: _____ Date: _____

Notarization:

On this _____ day of _____, _____, _____
(date) (month) (year) (name of parent)
personally appeared before me in _____ County (in the state of _____)

and, in my presence, signed this medical release form.

Name of Notary Official: _____
Signature: _____
Commission Expires: _____