



MEDICAL RELEASE FORM

I hereby give permission for any and all medical attention necessary to be administered to my child (name) _____ in the event of accident, injury, sickness, etc., while they are under the care of the person(s) designated below, until such time as I may be contacted.

If neither of the persons designated below can be contacted, I give permission for treatment of my child as may be required and determined by the appropriate health care professional who is present.

This release is effective from (date) _____ to _____. I hereby assume responsibility for payment of such treatment and have attached my child's insurance information.

Parent/Guardian Name: _____	Home Phone: _____
Work Phone: _____	Cell Phone: _____
Home address: _____	
City: _____	State: _____ Zip: _____
Insurance Policy Number: _____	Company: _____
Child's Physician: _____	Phone: _____
Physician's Address: _____	
Known allergies or medical conditions of child: _____	

Medications child takes: _____	

In case I cannot be reached, either of the following is designated to make medical decisions:	
Name _____	Phone: _____
Name: _____	Phone: _____
Parent/Guardian's Name (print): _____	
Parent/Guardian's Signature: _____	Date: _____