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Medical Release Form

Name: _____

Birthdate: _____

Parent: _____

Phone #: _____

To whom it may concern:

As a parent and/or legal guardian, I authorize the treatment by a qualified, licensed medical doctor of the following 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 contact me using any or all of the methods listed below.

Name of minor: _____

Relationship: _____

Home # _____

Work # _____

Cell # _____

Family physician: _____

Phone # _____

Family dentist: _____

Phone # _____

Insurance co: _____

Policy # _____

Please list any medical allergies, chronic illnesses or other conditions: _____

Other contact in case of emergency:

Name: _____

Phone # _____

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

Signed: _____

(father, mother or legal guardian)

Date: _____