



# 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 #: \_\_\_\_\_

**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.

Signature: \_\_\_\_\_

Name of Notary Official: \_\_\_\_\_

Commission Expires: \_\_\_\_\_